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ORIGINAL ARTICLES

THE OPENING OF THE PONDVILLE CANCER HOSPITAL AT NORFOLK, MASSACHUSETTS, JUNE 21, 1927*

THIS hospital was created under authority of the Legislature for the care of patients suffering from cancer under the Administration of The State Department of Public Health and is one of the first institutions of this kind in this country.

After inspection of the plant the meeting was called to order by Dr. George H. Bigelow, Commissioner of Public Health. The program consisted of the following addresses:

OPENING ADDRESS

BY HIS EXCELLENCY ALVAN T. FULLER
Governor of Massachusetts

WE meet here today to open and dedicate an institution to fight one of the greatest scourges that has ever afflicted mankind. It kills five thousand of our fellow citizens annually. The number is continually increasing.

It is a red-letter day for Massachusetts. It represents the "farthest north" movement, if you please, in the fight against cancer by any state in the Union. I shall not attempt to talk about cancer as a disease or any of its possible cures, because I do not know anything about that; and sometimes I think that some of the medical profession do not know as much as they pretend. But I am glad to say that we do not enter the arena boastfully. We admit it is a dread disease. There are certain things we do know about it. We know for example that State aid in restraining the ravages of this dread disease will be particularly effective for two reasons: first, cancer is something that people are usually secretive about. They dread the possibility of having it. They feel that if they have it that it is incurable. And all those things lend themselves to a secretiveness and a lack of initiation and effort toward its cure. These very facts would suggest the wisdom of placing at the service of our people, at strategic points that will cover our population, clinics where they may go, without charge, and consult in regard to cancer, and from where may be disseminated information that has to do with the cure of this dread disease.

Particularly are these efforts wise when it is

*See Dr. Bigelow's notice in regard to the Pondville Hospital on page 587.

realized that the most effective cure for cancer is to take it in time. Of cancer it may be in very truth said that "A stitch in time saves nine." And so I say that we of Massachusetts can be very proud, it seems to me, of this new effort which means so much in giving aid and comfort to those who not only most need it, but because it has great possibilities as a preventive.

Now I told you that I was not going to talk about cancer in a technical way because there are men here who can speak with authority. But I do want to touch upon a phase of it because I think it is related to this cancer policy of the State, in connection with which this hospital is concrete evidence. In conjunction with this hospital there will be operated twelve clinics, located in Lowell, Lynn, Newton, Springfield, Worcester, Brockton, Fall River, Fitchburg, Greenfield, Lawrence, New Bedford, North Adams or Pittsfield.

At the opening of one of the clinics a woman presented herself who had sustained a slight injury to the breast some two years ago. She had heard of the association between cancer and injury and she was fearful. Because of her self-consciousness she thought she noticed slight twinges that she would otherwise have ignored and the fear became a certainty. Lest someone should pronounce sentence, she avoided consulting a doctor and did not even mention it to her friends. Under this appalling cloud of disease and death this woman lived alone for two years.

Something in the newspaper announcements of the clinic won her confidence. After a careful examination she was told that she did *not* have cancer and the cloud was dissipated. Who shall say that the service to this woman was not as great or perhaps greater than that to two others at the same clinic who had their cancer removed within five days with every prospect of cure. Such instances are occurring daily in clinics and private offices as a result of the service and the knowledge of the proper use of the service which is available. This is the crusade against cancer which should inspire the very greatest enthusiasm in all of us since at any hour it may strike us or someone we hold dear.

The matter of an appropriation for fighting cancer came up in the Legislature in its closing days. There was quite a demand at that time that Massachusetts should be represented at the Sesquicentennial Exposition in Philadelphia. Other States had built State buildings there. A Pennsylvania delegation had visited Massachusetts. There had been a great deal of agitation for a larger appropriation so that we should be represented there. It was pointed out to us that we were one of the thirteen original states and as such that it would be very unfortunate if Massachusetts was not as well represented as Connecticut, New York, and some other States. I think Connecticut made an appropriation of \$150,000 and New York of \$250,000 or \$300,000. But we withstood the temptation. This building here today is possible because we vetoed the foolish expenditure that might have been made for a building at the Sesquicentennial. If we had made it, it would not have done us a bit of good; we would not be a bit better off today; whereas now we are embarked upon the policy that is going to save a great many lives and avoid a great deal of suffering, and prevent a great deal of sickness, and which represents a real service on the part of the State and the people.

Why, I hear people talk about socialism! They are afraid of what the socialists will do. I am not a bit fearful of the socialists or socialism, provided we can keep our government devoted to the interests of the citizens rather than that it should be used in one way or another for the benefit of private individuals or groups seeking special privilege and advantage of one kind or another.

Now I want to say a word to you about the political side of this cancer movement, because after all, this is your business, and I think the more the people know about the State's business, the more intelligently it will be handled. Not only will suggestions come from the people themselves, as they are familiar with the State's business, to their political representatives; but their political representatives can also be more progressive in their undertakings, confident they will receive from the public at large intelligent support.

There are two extreme views in regard to public expenditures that are entertained today. One is for economy, regardless of public needs—rabid economy, and the other is the political point of view of favoring this expenditure or that expenditure or the other that may be supported by some organized minority. The result is that hundreds of thousands of dollars in the State of Massachusetts are wasted every year on ridiculous undertakings of one kind or another in which, practically speaking, there is no advantage. Some of these undertakings may be of advantage to a few, but the people's interest by and large is not furthered one whit by

some of these expenditures. These extravagances are only possible because people elect their representatives and then fail to follow what they are doing carefully.

I think you men and women realize that if you were left an estate by one of your forebears, you could hardly have an executor appointed whom you could trust to run your affairs without giving them any attention yourself. If you did allow your affairs to be run that way, they probably would be run into the ground.

That is the way the State's affairs have been run. I don't refer particularly to Massachusetts, but I refer to city and town and county affairs. Every once in a while you read, even in the intimate affairs of small towns, where the Town Treasurer has been helping himself out of the Treasury without any hindrance on the part of the taxpayers for years. I simply cite that as another example of the individual citizen's neglect of the public business. What I am driving at is this: this cancer hospital—this undertaking on our part which will mean so much to so many people—is possible because of wise and sensible economies and not by any added tax levy. I wish we could continue along this line to substitute real helps to the people of Massachusetts in their real problems for the silly expenditures on needless matters.

From time to time I have had occasion to enumerate some of the unwise expenditures in which the State is indulging. I propose to keep battling along this line, and I hope you will think it is pardonable when something like this has been accomplished to point out that it represents progress.

I would improve this opportunity of expressing my appreciation of the service rendered our citizens by the Legislature which authorized this cancer appropriation and my confidence in the medical staff under Dr. Bigelow and Dr. Greenough who will administer it.

CANCER AND THE MEDICAL PROFESSION

BY JOHN M. BIRNIE, M.D., F.A.C.S.

President, Massachusetts Medical Society

THE subject, Cancer, and the medical profession means the attitude of the general practitioner of medicine toward the Cancer problem and involves his duties and responsibilities in connection with this increasing scourge of the human race. To be sure, Cancer, for the most part, is dealt with by men specially trained in its detection and treatment but in the last analysis, it is the general practitioner of medicine who sees the beginning and the end of Cancer. In our groping after the cause of the malady and in our endeavor to halt its ravages, we are handicapped by lack of exact knowledge. This lack of knowledge is in no way due to deficiency

of effort, for the best minds of the world are concentrated on the problems involved and vast sums of money are being expended in research and in the tabulation and correlation of facts and figures which may in any way aid in the solution of the question. Ninety per cent of human ills are first seen and mostly treated by the general practitioner of medicine and these men today, control the battle against Cancer.

The efficaciousness of any known treatment, be it surgical, radiant or what not, depends upon the promptness with which it is instituted, and it is the general practitioner of medicine who controls this vital element of time. Whatever fault there may be in delaying the institution of treatment, it cannot be attributed to a disinclination on the part of medical men to act promptly in clearly diagnosed cases of Cancer, but in their strong tendency toward procrastination in the doubtful cases although it is only by attacking these that the conflict with Cancer may be won. To await a diagnosis on purely clinical grounds is to invite failure when success is within one's grasp. One must have knowledge of what enlightened treatment has to offer and he must be willing to act on pure suspicion. Better by far, to seem over-zealous and pessimistic than to overlook one case and belittle the seriousness of a seemingly slight complaint.

The general practitioner of medicine is probably somewhat justified in his skepticism concerning the treatment of Cancer. He has seen the rise and fall of so-called cures. He has watched with eager interest the progress of many so-called developments which have led nowhere. He is in a state of bewilderment and doubt. Back to him, after treatment, comes the high percentage of failures. Upon him devolves the duty of ministering to one doomed to suffering with every ray of hope extinguished. No wonder that the general practitioner may seem to lack enthusiasm for the fight, yet, he plods doggedly on doing his duty as he sees it and he will be the first to grasp any real aid emerging from the haze for he, above all others has a personal realization of the curse of Cancer.

The opening of this hospital today, offers to the general practitioner of medicine in Massachusetts one more weapon for his armamentarium in fighting Cancer and, as such, I know that he welcomes it most heartily. The founding of a State Cancer Hospital is but one cog in the machinery which the Commonwealth has set up for the relief of malignant disease. The establishment of clinics throughout the state, the purchase of radium and the dissemination of knowledge is all part of a wisely constructed plan. Wisely constructed but frankly an experiment. The executives of our new policy have little on which to base their procedure and time and experience may necessitate numerous changes. In undertaking to advise and treat patients suffer-

ing from a chronic disease without regard to financial status is a departure in the annals of the state. How the patient suffering from Cancer will react to this new program is entirely problematical. The patient, of course, is the base of the entire structure and to a certain extent his whims and fancies must be respected. He will determine to a large extent the success or failure of our program as laid out.

I have no apprehension concerning the attitude of the medical profession toward our new opportunities. Medical men have always been among the first to contribute their support to any and all movements which have as their ideal the relief of suffering, the prevention and cure of disease and the general progress of the world toward a higher plane.

CANCER AND THE PUBLIC

BY ROBERT W. KELSO

*Chairman, Advisory Cancer Education
Committee*

THE learned physicians gathered here may tell you that the problem of cancer is a problem of surgery. I tell you that it is first and foremost a problem of health education. With reference to this disease we are almost exactly in the position our forefathers were in regard to smallpox, in that day when good Dr. Boylston advocated inoculation. Our ancestors did not know what smallpox was, but they did know that quarantine prevented its spread. Their explanation of disease sounded more in belief than it did in reason. Lacking a scientific explanation they used their imagination,—they turned to superstition. Inoculation would, of course, be an interference with the supernatural. Consequently they invited Dr. Boylston to a necktie party and in fact pursued him with a rope in which the noose was already prepared.

Today we do not know what cancer is, any more than we know what life is; but we do know a good deal about it. Our scientific men know that it is a degenerative disease; that it has a painless, insidious beginning; that it seems to arise mostly out of irritation of some sort; that it seldom attacks before middle life; that it has an early stage during which it appears localized and yields in many instances to surgical operation; but that after such early period of quiescence it appears to run wild in the system, at which advanced stage the patient has little chance.

I say, our scientific men know these facts. The rest of us may read them; have heard speakers talk about them, and have met some of them first hand in the hospital. But for the most part our ignorance of cancer is deep and impenetrable as the Grand Canyon in a fog. The American citizen believes what he wants to believe

and gives ear to that which is likely to give him pleasure. He shuns pain and will shut out of his mind those thoughts which do not give pleasure. He makes his decisions in life on a basis of sentiment; not reason. He responds to his emotions rather than to his reasoned judgment. Love will drive him to heroism or suicide; hate to murder; fear to behavior the most illogical. Reason touches him not at all.

Hence it is that the vendor of nostrums, the electrical occultist and many another of the tribe of blood sucking parasites who fatten on the fears and the credulity of the necessitous, persist among us. Each genuine invention or discovery of the laboratory brings its separate crop of frauds. When electrical mechanism became a fact—it is only fifty years ago—we had the quack with the marvelous battery. It shook you back into health! Now that we have the violet ray we discover the quack with the wonderful ray—on which the violets are usually painted!

The public puts up with this: the public likes it. We all laugh at it—all but that sad and numerous company who walk in the shadow of death.

And so I repeat. The major problem in cancer as with every other unconquered disease, is not the isolation of its germ or the detection of its various causes, vital as that quest may be. The great problem is the making of what we now know of the disease the common knowledge of the people. Reduce it to cryptic terms, and the task comes almost to this single statement: Secure understanding and then action; you thus have a chance. Catch it early and you have a chance; delay and you are lost.

How shall we do it? We do not need to increase the dread of this disease in which the public stand. We do need to quicken in the mind of the person fearing cancer the courage to know the worst and to know it at the earliest possible moment. We need to visualize in the consciousness of the prospective victim of this disease the safety that lies in quick diagnosis and action and the hopelessness of waiting,—by all means the folly of temporizing and rubbing salve on a cancer.

This we cannot do by some preachment from the medical pulpit. A precept is flat; it has but two dimensions. It sounds in reason and leaves the emotions cold. The method we use must be dramatic. It must have three dimensions. It must stand up like an object before the eye. It must walk and appear to one like the ghost of Hamlet's father. It is by this means only that the public imagination can be fired to the point of action.

The means for such a dramatic yet rational demonstration we now have. The Massachusetts program for Cancer Control contains two major elements: first a system of clinics for the diagnosis of cancer; and second, this hospital

for the treatment of persons not cared for elsewhere. The clinics are placed locally, where the people can reach them. They are the people's own, where anyone may go for a determination of his question; even though it may not turn out to be cancer. There could be devised no better actual working exhibit than the local clinic; no system calculated so well to quiet the dread and the fear of the individual; no place so likely to encourage him to come early and learn what if anything he should do to protect his health. The clinic is a primary instrument of education, familiarizing the public with the common sense course to take with cancer. The hospital as an element of the State system is more than questionable. But we have it, and the legislature was emphatic in insisting upon this feature of the plan. For those who come here for surgery or for deep therapy and go back to their several communities, the hospital should serve as a demonstration. Each ex-patient should go as a missionary back to his neighborhood encouraging personal friends when in doubt to visit the clinics.

But to make the clinic thoroughly effective, this hospital should take no cases that do not come to it through the clinic and upon recommendation therefrom. Again, hospitals now existing should not seek to unload their extra burden of expensive cancer cases upon the State Hospital. These few beds should remain as was intended in their establishment, as an addition to existing facilities, to be used for new cases, and not merely as a replacement. When the State undertakes to provide hospital care for persons regardless of the time-honored qualification of public dependency, a new and serious step in community action has been taken. Clear thinking and much care must be used to preserve the program as a genuine educational instrument addressed solely for the preservation and improvement of the public health.

NATIONAL ASPECTS OF THE CANCER PROBLEM

BY GEORGE A. SOPER, PH.D.

THE American Society for the Control of Cancer, whose spokesman I have the honor to be on this occasion, desires me to convey to you its felicitations, and say that it is keenly alive to the significant work which Massachusetts is doing to combat the plague of cancer, and that it wishes you every success.

The American Society for the Control of Cancer was organized fourteen years ago to lead a nation-wide war against a disease which we are coming to recognize as chief of the captains of death. The Society has branches in every state of the Union. In the course of a year no less

than 25,000 voluntary workers are engaged in fighting under its guidance.

One of the earliest and best state branches of the Society was established in Massachusetts. I believe it is largely to the instruction given to the public and to the sympathetic understanding brought about in the medical profession through the efforts of Dr. Robert B. Greenough, Dr. Edward Reynolds and their associates in the Massachusetts branch of the Society that the remarkable awakening of interest in cancer in Massachusetts is to be ascribed.

I have been asked to speak about cancer as a national problem. In the time available, we can take but a glance at the subject, but what we shall see is impressive.

From careful estimates based on the latest returns of the U. S. Census, over 103,000 people die of cancer in the continental part of the United States every year. All parts of the country, all races, all classes and both sexes are affected by it. More people die of cancer than of all the infectious diseases combined, excepting tuberculosis. More people die of cancer than are killed by railroads, street cars, automobiles, fires, drowning, mining accidents, machinery, poisons, homicides and suicides,—all put together.

Cancer is the most fatal disease known to modern civilization. Practically every case is fatal unless it is treated skilfully and in its early stages. More than one in ten of the men and women now living are destined to die of it. Of all the women who die between the ages of forty-five and sixty-five, one in five succumbs to cancer.

The number of persons between the Atlantic and the Pacific who are suffering from cancer today is about 300,000. The cost of cancer to the people of the United States has been estimated at over a billion and a quarter dollars a year.

The statistics just quoted are based upon government figures. There is reason to believe that they are too small to show the true magnitude of the cancer menace. The situation is becoming more and more alarming. The official death rate is increasing nearly 2% a year.

What should be done about this plague of cancer? First, let us consider what is being done. It will take but a moment.

The General Government, through the Public Health Service, is making some statistical studies, but they are not very extensive or intensive. It would be glad to know what to do to prevent cancer. Nobody knows. The improvement of environmental conditions has no effect upon cancer; there is no doctrine to preach with respect to general health; no restrictions to impose as to food or water supplies, immigration or transportation.

The departments of health of our forty-eight states take little or no notice of cancer beyond

publishing routine statistics and occasional pamphlets about it for general distribution. City health departments do practically nothing. The usual attitude of official public health agencies is that money can be spent in other directions more profitably. There are exceptions, but they are so few as to make conspicuous the lack of practical work done against this great scourge. Boards of health do little because they do not know what to do to control the disease.

Health demonstrations promoted by private philanthropic foundations, whose object it is to show how great a saving can be made in life and health through the operation of well considered programs, adequately supported with money, do not include cancer among the diseases to be combated.

The Massachusetts crusade will be anxiously watched by the whole world. Its object is not to eradicate cancer but to reduce its fatality. This is all that present knowledge admits of. Some cases can be prevented but thousands need to be treated. For the first time one of our states has set about to provide adequate medical attention for all who have cancer and to induce the public to make the fullest use of these facilities.

The Massachusetts plan is to be compared with the organized efforts which are being made in France, Switzerland and Belgium to combat the scourge through the establishment of centers in which provision is made for diagnosis and the treatment of the sick, for research and for the instruction of medical students. It will be contrasted with the British Empire Cancer Campaign, which set out to find a way to control cancer through the stimulation of research by grants of money obtained by popular subscription.

The fundamental theory upon which the work of the American Society for the Control of Cancer and the Massachusetts work are being carried on is that many patients can be cured if they can be treated skilfully and in time. There are certain preventive measures which are advocated, notably the avoidance of the chronic irritations which frequently precede cancer, but in the main the procedures recommended are remedial. They call for a high degree of skill on the part of the medical profession and knowledge, intelligence and initiative on the part of those who are to be protected.

The early diagnosis and proper treatment of all but the most easily recognizable forms of cancer call for team play and the members of the team must all be exceptionally skilful in the work which they are called upon to do, if the disease is to be discovered and properly treated before it has reached an incurable stage.

The cancer survey made by Massachusetts two years ago showed that even in this advanced commonwealth the provisions for the diagnosis and treatment of cancer were inadequate. At

least three hundred more hospital beds were needed for the advanced and terminal cases and greater facilities in the way of diagnosis and treatment were required for the early and doubtful cases. If the same conditions exist throughout the United States, and there is no reason to suppose that they are better anywhere, there is need of several thousand more beds than our hospitals now provide, and scores of diagnostic clinics.

How are the additional facilities for treating the cancer sick to be provided? The people of Massachusetts have made a plan. They have expressed their will through the legislature. The burden of carrying out their instructions has been placed upon the State Department of Health. It is something new for such duties to be entrusted to an official public health agency. The task of establishing and maintaining hospitals for the degenerative diseases has not hitherto been undertaken by this branch of government. To bring about cancer clinics throughout the state, so that everyone who needs skilful attention can receive it, calls for the solution of many medical, social and economic questions of a highly complicated and special character.

It is understood that the work which the legislature provided for, and which the State Department of Health is accordingly carrying out, is meeting with success and general approval and that the public and the physicians of the commonwealth are giving it their active support.

The opening of the Pondville Hospital is one of the prominent features of the enterprising program. This hospital was at one time believed to be designed as a place for incurable cases only. It is earnestly to be hoped that it will not be dedicated to that sole purpose. It must not be a place of dread, despair or gloom. Some patients must be sent there who have a good chance of being made well, for the encouraging effect which their recovery will have upon the others. The morale of the institution will need to be sustained. Toward this end, it will be well to make the grounds beautiful and to provide appropriate occupations and diversions for the sick. It is possible to visualize a refuge for cancer patients at this place which will be pointed out by thousands of persons who motor by on the neighboring highway as a fine example of the care which the state is bestowing upon its unfortunates. It would seem desirable that Pondville should be linked up with the clinics in an effective way.

One of the interesting aspects of the Massachusetts program lies in the fact that no specific provision has been made for research. Perhaps experimental work is thought to be sufficiently provided for already. Boston is one of the best recognized centers of cancer research in the world. But clinical research should form a

prominent feature of the work of this and all other cancer hospitals.

The international meeting on cancer control held in America last fall declared that research and the practical application of existing facts should stand shoulder to shoulder in the war against cancer. More money, a great deal more money, should be available throughout the United States for research. The word "research" should be interpreted in a broad and liberal sense. It properly applies to the advance of information by observation and experiment in every direction in which progress is needed and should not be confined, as is customary, to laboratory experimentation.

More money, and a great deal more money, is everywhere needed for the establishment and support of hospitals and clinics. Whether special hospitals are required, or added facilities should be provided in connection with hospitals already in existence throughout the country will depend largely upon local circumstances. Each has its merits and probably its place.

More money, a great deal more, is needed to pay the cost of the educational work which needs to be done in the United States to teach the public and to inform the medical profession of the latest advances in knowledge of what can and should be done and to arouse people to the necessity of an organized and vigorous warfare against the scourge. Science and the social machinery which in recent years has been developed to a high point in combatting other diseases must be focussed upon cancer. We must learn what to do and do it with a will.

This latest plague to be dragged out of its obscurity and revealed in all its hideous proportions must be conquered by a united and determined warfare. In this, as in other undertakings of profound importance to the welfare of the American people in the past, the Commonwealth of Massachusetts is leading the way.

CANCER CLINICS

BY WILLIAM T. HOPKINS, M.D.

Mr. Chairman, Your Excellency, Ladies and Gentlemen:

I am sensible of the honor of an invitation to address this gathering and I esteem it a privilege to speak concerning the Cancer Clinics.

The establishment of a cancer clinic is beset with difficulties, the first of which is the name itself. Some have thought that other names might be more suitable but it appears to me that any title other than cancer clinic is something less than straightforward.

In support of the contention that a community need for such clinics exists, it may be stated that although we believe that early cancer can be cured, the mortality from cancer continues

to increase. It is furthermore a fact that as soon as these clinics open patients appear. The proportion of cancer patients reached by the clinic may perhaps be indicated by our brief experience in my own community. The average annual cancer mortality of residents of Lynn for the years 1923, 1924 and 1925 was 123. With this figure as a basis of computation, Lynn should now contain approximately 250 living cases of cancer.

Our clinic opened on April 22 and has since been conducted weekly. In less than two months we have seen between ten and fifteen per cent of the entire number as estimated. So much for the need of such a clinic.

Quality of service is of the first importance, and must comprehend doctors of skill, hospital facilities, available consultation service in all specialties, x-ray opportunities and access to radium. The conduct of the clinic must be strictly ethical. The quality of the follow up work is of greater importance than in almost any other field of medical activity. An accurate and comprehensive record of cases is of the first importance. The coöperation of the profession is essential. Full understanding by the laity is the new feature in the cancer campaign, and upon its accomplishment depends the success of the effort at better cancer control, in my opinion. The lay committee can perhaps reach the public where the profession has failed. A campaign of publicity is absolutely necessary. In this effort the value of newspaper publicity can scarcely be overestimated.

The possible benefits of a cancer clinic appear to be in addition to the relief of the individual patient, the focussing of public attention upon the subject of cancer, the stimulus to professional interest in cancer, the causing of an increased number of persons to visit not only the clinic but the family physician as well. The effect upon the profession of intensive work in any branch is a stimulation of zeal in all fields of medicine. I confess that I embarked upon this undertaking with scant enthusiasm when first approached upon the subject by the Commissioner, but after observation of the operation of the clinic for even this short time, I feel much more confidence in the possibilities of ultimate benefit to this class of sufferers, by this method of attack.

The good already accomplished by the clinic may be said to be the relief of late cases, operation with hope of cure of early cases, and the immeasurable relief of those who have no cancer but have been harboring the fear that they are victims of the disease. It may be contended that the clinic has fulfilled no important office by furnishing advice and treatment to late cases which merely change their advisers, but surely the cases which have previously consulted no doctor and the early cases which have been operated as a result of advice received at the

clinic constitute a group, concerning which this pessimism is unwarranted. In my own city the response to the cancer appeal on the part of the public has been satisfactory up to the present time. The Lay Committee has exhibited the same fine spirit which is characteristic of the membership as individuals in whatever capacity they are encountered; the civic organizations were a surprise and a delight. Their instant response was dramatic. The hospital management has shown great interest and has rendered every assistance possible. The newspapers have been our greatest aid.

The medical profession is of necessity conservative, and may be expected to endorse any new departure from customary procedure only after careful consideration. Any apparent lack of enthusiasm may be attributed, I think, to the inertia of a large group of persons accustomed to conservatism of thought. The medical profession will continue its careful, conscientious, scientific, skillful, considerate care of suffering humanity, unheeding the slurs of the ignorant and the careless, not too mindful, either, of such praise as may be accorded, and in any well considered measure for the alleviation of human suffering it will coöperate.

A liaison should be established between the cancer clinics and the Pondville Hospital. Not only terminal cases should be sent from the clinics to this hospital, but others who are in need of radium treatment or certain special operative procedures or perhaps, observation requiring unusual skill or technique.

It seems to me that if all who are in any way associated with the cancer problem would have one thought always in mind in connection with their cancer activities, and all would have the same thought, some progress may be made. That thought should be "the better control of cancer."

CANCER AND PUBLIC DEPENDENTS

BY JOHN H. NICHOLS, M.D.

TODAY our State in her leadership has added another special institution to those excellent ones already operating for the care and relief of the varied unfortunates; the School for Crippled Children at Canton, Department for Defective Delinquents, Bridgewater; Psychopathic Hospital, Boston; Hospital for Epileptics, Monson; School for Feeble Minded, Training Schools; sanatoria for tuberculosis at Rutland; for non pulmonary cases by heliotherapy at Lakeville; for children and preventorium cases at North Reading and Westfield, and others.

It seems to me that one of the most valuable and humane services that we hospital people, especially in the state service, can render in these days of high cost of living, sickening, dying and burying, is to demonstrate how inexpensively we can build, equip and conduct these

hospitals with the necessary requirements, comforts and sanitary conditions included, but without the innumerable luxuries and unessential equipment that are of course delightful and helpful but increase the cost far beyond the proportionate advantages gained. We should strive to see how small we can make the cost of care, so that we will not make dependents out of people whose accumulated earnings are meagre and cannot, for more than a few weeks, stand the excessive rates that have to be charged by hospitals today.

I am optimistic enough to believe that the cure of cancer will soon be established, that it is "just around the corner" but the trouble is that none can say how soon it will be an actual, practical working cure. In the meantime we will have to care for these cases without specific remedy as in the past, although radium is a wonderful present day adjunct. Of course, the cure will be discovered and established, perhaps in London, or Paris, Berlin, Toronto, Ann Arbor, Baltimore, Pittsburg, Boston, Pondville or Tewksbury, it will come but we do not know just how soon.

However, there is one great step already made that we celebrate as a part of this establishment today—the cancer clinics, and if others equal in enthusiasm of the staff and the number of patients examined, the clinic in Lowell under the leadership of Dr. Martin, the honored Chairman of the Trustees of the State Infirmary, and a member of the Advisory Cancer Education Committee, we are not only going to accomplish all that we could hope, for the patient and the cure of the disease, but will also be conducting a general crusade for good health, in uncovering other diseases and conditions which will be directed to the proper channels.

My service has brought me in contact with 133,680 public dependents in 36 years, of which number 118,338 or 88.5% have been sent back into the community and ceased for awhile at least to be dependents. 15,342 or 11.5% have died. 7.5% of these deaths, or 1 in 13.5 have been of cancer. There have been 1141 deaths of cancer in 36 years but these are almost invariably patients who are admitted with cancer already advanced. Very few cases of cancer develop among those for a long while in the institution. Among our insane patients most of whom have had a very long institutional residence, there have been only 50 cases in 2158 deaths, 2.8% of 1 in 35, while in the community outside "1 out of every 9 over 30 years of age is likely to die of cancer."

That "Massachusetts has the highest death rate for cancer, second highest rate for heart disease; sixth for diabetes and cerebral hemorrhage," are unenviable facts that need explanation, and when given publicity without comment disturbs my equanimity. It does not sound like

Massachusetts with her enviable leadership in 30 many other lines.

"Cancer increases in Massachusetts with the density of the population, from the small rural communities to cities, or a density of around 4000 people to the square mile," which is consistent with the facts that: (1) "Cancer is rare among the rural population." (2) "Massachusetts has the highest cancer death rate." (3) "Cancer is rare in people with a long residence in institutions," which are all situated in the country. (4) "Cancer is still on the increase in Massachusetts." Let us reason and at least suggest something for a remedy.

Of all of the United States, Rhode Island only has a greater density of population than Massachusetts, which density increased from 221 per square mile in 1880 to 479 per square mile in 1920.

Cancer which we have called "a disease of civilization" coincident with density of population, would hardly be expected to claim in this state a death rate at least not lower than second of the states. Acknowledgment is due to Rhode Island for her performance in securing the second place, which should have been ours.

"From 1900 to 1920, Massachusetts' population increased from 2,805,346 to 3,832,356. The Urban population increased 1,083,150 and the rural population lost 36,176, in 20 years.

"Cancer deaths were 4.12% in 1900, increased to 7.75% in 1920."

"Cancer deaths 1993 in 1900 reached 4400 in 1920 an increase of 2407 in 20 years." There are only 4 smaller states in the Union than Massachusetts with 8000 square miles area.

"Massachusetts has 5000 cancer deaths per year."

Our population should be moved back into the country. With 8000 square miles area there is still most ample space for spreading out, and plenty of undeveloped, or abandoned farming or gardening land for the ideal requirements of rural living.

The continued condition of unemployment in the industrial centres during the last 6-8 years, also gives a reason for redistribution into the country for rural employment. We have been mildly advocating the back to the farms movement for a quarter of a century or more, but cancer in this state has been increasing rapidly for three quarters of a century, while the majority of the fine old farms and dignified country dwellings of 75 years ago, have long since yielded to decay or fallen into hands of shiftless, unappreciative owners. Old Dr. Rip Van Winkle must have been sleeping more than sixty years, and now in desperation we would reach back through those years to the source of all the health and comfort of the earlier days to save us from our present peril.

No longer do "Folks want their doctors mouldy like their cheese."

In the words of the immortal Whittier, still "Ther's iron in our Northern springs," "Our pines are trees of healing," and for the "bare-foot boy" there yet is "Health that mocks the doctor's rule."

We are proud of the reduction of state debt and that we are one of the wealthiest of states. Yet we let the deserted homes and villages decay while we succumb to cancer in the city. Even now we are allowing railroads to tear up miles and miles of track that were laid out into rural districts, over seventy years ago.

Prevention is the order of the day, our greatest hope; and the best preventorium of which we know is our vast rural "out of doors," where natural, healthful exercise and labor must be done; where the great life giving element, unfiltered sunlight abounds with freshest air and water, fragrant fields and grateful shade; the simple life and peaceful scenes and quiet nights. There good old Mother Earth with her mellow fields supplies fresh fruits and vegetables, her honey, butter, cheese and milk, eggs, her berries, apples, grapes and nuts; fresh poultry, pork and other meats that have not been preserved, or kept, or iced, or stored for such a length of time as might allow some subtle changes or decay that are as yet unknown, and uncontrolled and yet that may embrace the riddle that we seek to answer in this dread disease. Our average people while they yet are well, placed in the country should reasonably continue in their health. After they are ill with cancer, we will bring them out here in the country to be cured. The city hospitals send their convalescents to the country. Physicians send their patients to the country "put them out to grass," or to the shore, there to regain their health. Hospitals, schools, sanatoria, preventoria, are in the country for cleaner atmosphere, violet rays, bathing, exercise and rest out in the open air; for fresher and more varied diets, vitamins and flowers and grass and trees and peeping frogs and crickets chirp, and songs of birds.

That prevention of disease is, in your own words Mr. Commissioner, the first purpose of the great department that you so ably lead, and in itself more worthy than the cure, will still with cancer be your aim, I cannot doubt. Even in the marvelous record of the fight against tuberculosis, with victory nearly won, you do not stop until you have established preventoria for general health, that children may no longer be susceptible to infection.

Is there not reason for belief that with rapidly increasing numbers of families taking up their permanent residence in the rural parts, that the cancer death rate and that from other causes, will recede? Is it not time for the State to open up more liberally for the health of all of the people? Of what good is her wealth, her

culture, her commercial prosperity, if one out of nine of her adults is liable to die of cancer long before his time.

I believe that the efforts of the State Government and departments, the Massachusetts Medical Society, Chambers of Commerce and social agencies, should be to move our population, as much and as fast as can be done back onto the land, back to nature, to create prosperity in rural parts once more, and I would ask my medical brothers wherein the principle I advocate can in any way be wrong?

Establishing new areas of density of idlers during summer months beside some lake or stream or railroad line, or thoroughfare out in a rural section does not fill the bill and often causes fully as much misfortune as it seeks to remedy.

Potential health and wealth and happiness are in the country life. We lost 36,000 in population in those districts from 1900 to 1920. If we could throw twice that number back into the country within the next 20 years we would have the movement of preventorium work well under way but the laws must be amended, or enacted toward this end, the compensation and opportunities made adequate to needs, and markets free and uncontrolled by dealers, jobbers and speculators, so that we can supply our own urban population here on Massachusetts Bay with fresh vegetables and garden produce from our own farms, now driven out by competition in favor of the products of the West even to the Pacific Coast. Cross roads should be developed, swamp land drained, educational, and social betterments effected to make the rural districts really free and livable and lovable. If there is any part of the country that needs farm relief measures enacted today, it is right here in Massachusetts, to provide marketing possibilities or adequate compensation, and to relieve the farmers from their unnatural bondage, their drudgery, poverty and slavery: the strangle hold, on rural life today.

With fair compensation the agricultural activities would quickly revive and create a rural wealth and prosperity soon rivaling our other industries. Our urban people need to spread out into the country for their future health. The farmers are in as much need of the patronage of their city dwellers as they are in need of the fresh products from the farm.

These two differing parties should reciprocate in favors, and co-operate for the common purpose, better health and safety from the same dread maladies. It will be an enormous undertaking. It may seem impossible of accomplishment but Massachusetts stands fifth in wealth among the states and should be ready to pay the price of her emancipation from the inglorious position that she holds among her sister states, in her death rate from cancer and from degenerative disease.

THE SERVICE OF THE PONDVILLE
HOSPITAL AT NORFOLK

BY ROBERT B. GREENOUGH, M.D., F.A.C.S.

THE act of the Legislature which authorized the reconstruction and equipment of the unoccupied State Hospital buildings at Pondville, and their operation as a hospital for cancer patients under the State Department of Public Health, marks a new and significant step in Massachusetts and in the United States in Public Health activities, and provides a central nucleus around which has been constructed a comprehensive plan to provide for that great and increasing number of the population which is afflicted with cancer, the best in the way of diagnosis and treatment that modern medicine can supply.

State Cancer Clinics and Cancer Institutes have already been established in other states such as New York and in other countries, not only for the housing and care of moribund patients, but for the diagnosis and treatment of more favorable cases, and for research into the nature of the disease. These institutions, however, have usually been isolated and disconnected; and quite in contrast with the work which will center around this hospital in Massachusetts. In this respect the Pondville Hospital assumes an importance far greater than its ninety-five beds appear to indicate.

Until we know far more of the cause or causes of cancer than we do at present there is little hope for a practical and effective specific cure for the disease in the sense that we use that word when we speak of quinine in malaria, arsenic and mercury in syphilis, and the various antitoxines and vaccination methods which modern science has developed in many of the infectious diseases.

Indeed, it is the sincere belief of many who are familiar with this subject, that not one, but many causes will be found capable of producing cancer, and that not one but many agents will be needed to cure the disease. In any case, until that time shall come, we must do the best we can with those non-specific methods of treatment, surgery and radiation, which are now available and although they fall far short of our ideal, it must not be forgotten that they are effective methods of treatment in a large and constantly increasing number of cases. A census of the number of cases in Massachusetts that have been cured of cancer by these agents would do much to establish the confidence of the public in these modern methods of treatment, and prove that cancer is far from being an incurable disease.

The great difficulty with these modern methods of treatment is that they are effective only in the early and local stages of the disease; but every physician knows that that is to a great extent true in the application of all remedial measures. It is the late case of general peritoni-

tis, not the early case of appendicitis, that dies in spite of the best operative treatment which can be supplied; and even the late and advanced case of diphtheria is too often fatal in spite of antitoxine.

To be effective all remedial measures must be applied promptly and the real trouble lies in the difficulties encountered both by the patient and by the physician in recognizing the disease in its early stages. It is in this respect that cancer differs so much from other diseases. Cancer may come into existence and even spread from its local point of origin and invade surrounding structures long before the patient is at all aware that anything is wrong. The disease itself in its early stages is usually painless and produces no feeling of sickness or fever, or any of the symptoms associated in the minds of the public with ill-health. It is usually only when some vital function is interfered with that the patient seeks medical advice, and at that time the disease may already have reached a stage beyond possibility of effective treatment. It is this insidious onset of cancer that is to blame for its mortality, far more than is the rapidity of its growth or the lack of suitable methods of treatment, and no effective measures to reduce the mortality of the disease can fail to take cognizance of this fact.

It is precisely upon these facts that the policy of the Public Health Department of Massachusetts has been determined, and, although the provision of additional hospital resources for advanced cases of cancer was a crying need, to provide these beds alone without making an effort to reduce the number of individual patients who may reach such an advanced and hopeless stage of the disease would be like providing special hospitals for hopeless cases of diphtheria without attempting to diminish the number of such patients by providing facilities for accurate diagnosis by culture, and for the prompt administration of the curative diphtheria antitoxine.

The Pondville Hospital at Norfolk will supply the best and most up-to-date treatment for cases of cancer in all stages of the disease. The advanced case will be given such so-called palliative treatment, whether by surgery or by radium or x-ray as will most contribute to the alleviation of distressing symptoms and the prolongation of life. The importance of the nursing service, and of the maintenance of a good morale will be nowhere more conspicuous than in dealing with these advanced cases; and it is astonishing to see the improvement in mental and bodily comfort that results from assiduous and devoted nursing in these distressing cases.

The equipment and the professional skill required to deal with advanced cases is the same as that employed in earlier and more favorable ones, and this hospital will thus be able to deal with such earlier cases as are accessible to it.

Being provided with the necessary radium and x-ray facilities it will be able to offer effective treatment in certain types of disease in which these methods are of proved curative value, without the necessity of referring the patient to Boston or to other more distant medical centers where such methods of treatment are available.

The diagnostic skill of the professional staff will also be available for consultation in such early and doubtful cases as may be brought or sent to the hospital by their attending physicians. The diagnosis of these early cases is attended by great difficulties and frequently reliance must be placed upon the actual pathological examination of tissues removed by an exploratory operation. Facilities for such examinations will be provided, and again resort to the more distant medical centers will thus be made unnecessary.

The pathological service of such a hospital is of great importance. Not only is the examination of tissue for exploratory operation essential in many cases to a correct diagnosis and thus to the proper subsequent treatment of the individual case, but the facts determined by the pathological examination of the fatal cases constitute one of the most important methods of advancing our knowledge of the disease. In this respect also the hospital is organized to provide efficient service.

The Pondville Hospital is thus equipped to deal with cancer cases of all varieties, and in all stages of the disease. It is a "cancer" hospital of the most modern type and thoroughly organized to fulfill this function; but its value to the community goes far beyond this point for it is the central nucleus for a state-wide group of affiliated cancer-clinics which are being organized in established hospitals wherever professional and material resources are sufficient to maintain them. It is upon these state cancer clinics that will rest chiefly the measures directed toward the early recognition and prompt and effective treatment of the disease throughout the State. The material and professional resources of the Pondville Hospital will be available to aid and to coördinate the work of these cancer clinics, and by these measures it is certain that a great reduction in the delay which now exists in the recognition of the disease, both on the part of the patients and of the physicians, will be brought about. From these cancer clinics correct information in regard to cancer will emanate, both to the public and to physicians, in every community in the State, and this again will be supplemented through the proper channels of publicity available to the State Department of Health.

The statistical study of cancer will not be neglected in this program. By the coördination of the work of the State Cancer Clinics with that of the Pondville Hospital, uniform methods of studying and recording cases will be

adopted which will give a mass of uniform data in regard to cancer cases such as has never before been made available for statistical study. Hitherto most of our statistical knowledge of cancer has been derived from mortality statistics; and these of course fail to include at all the cured cases of the disease. Already, in one favorable community, a morbidity survey of living cancer cases is being made under the supervision of the State Department of Public Health, a study such as has never before been undertaken in any large community, and one which promises results of the greatest value in the study of this disease.

For some years now the State Department of Public Health has maintained a free diagnosis service available to every physician registered to practice in Massachusetts for the examination of tissue suspected of being cancer. During the past year some two thousand specimens were examined and reported on by this service, and there is no doubt that this accurate information has been of the greatest value in procuring early and effective treatment in many cases of the disease.

All of these activities together constitute one of the most complete and effective campaigns against cancer which have been made in any community here or abroad, and the people of Massachusetts may confidently look for a material diminution in the mortality from cancer in the future, thanks to the progressive policy of the State Department of Public Health, and the confidence and support of the medical profession of the State which the Department of Public Health has won and holds.

PUBLIC HEALTH SERVICE ANNOUNCES CHANGES

APPOINTMENT of Surgeons F. A. Carmelia and R. C. Williams as Assistant Surgeon Generals and the transfer of Assistant Surgeon General S. B. Grubbs to the field was announced orally September 19 by the Surgeon General of the United States Public Health Service, Dr. Hugh S. Cumming.

Dr. Williams under the realignment has been relieved from duty in the Division of Personnel and Accounts, and detailed as Assistant Surgeon General in charge of the Division of Sanitary Reports and Statistics. He succeeds Assistant Surgeon General C. C. Pierce, who has been designated Chief of the Division of Personnel and Accounts, with the rank of Assistant Surgeon General.

Assistant Surgeon General Grubbs, who has been in charge of the Division of Foreign and Insular Quarantine and Immigration, has been assigned to duty as Director of District No. 3 of the Public Health Service, with headquarters at Chicago. He is succeeded by Dr. G. A. Carmelia, who assumes the rank of Assistant Surgeon General.—*U. S. Daily.*

Case Records
of the
Massachusetts General Hospital

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN
WEEKLY CLINICO-PATHOLOGICAL EXERCISES

EDITED BY R. C. CABOT, M.D.
F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 13401

AN OBSCURE INFECTION

MEDICAL DEPARTMENT

A married American woman fifty years old, a telephone switchboard operator, entered April 12 complaining of shortness of breath.

She had noticed this symptom somewhat for two years. Occasionally she had noticed very slight swelling of the ankles. She dated her illness from two weeks before admission, when she was awakened from a sound sleep by a real chill which caused the bed to shake. With it she had frontal headache. She took a hot mustard foot bath, drank some ginger tea, put on a bath robe and for the remainder of the night slept very soundly. The following morning she found her temperature 101°. A physician prescribed a dose of salts and "salicon." She took two pills every hour for four days, about forty pills. During these days she slept nearly all the day, took only orange juice and water, had fever ranging from 101° to 103°, headache and painful neck. On the fifth day she had diarrhea of eight or ten watery movements and gripping pain throughout her abdomen, relieved by movements. These symptoms persisted until the day before she entered the hospital. On the seventh day she began to have dyspnea,—a feeling of suffocation somewhat relieved by sitting up and palpitation with rapid forceful heart beat. The fever persisted until admission. She had no cough. April 9 her physician prescribed digitalis. After the first two pills the palpitation and dyspnea stopped. Two more pills had no effect.

Her father, eighty-one years old, had rheumatism. The patient had one son living and well. She had scarlet fever at four years and diphtheria at seventeen. Before the birth of her son she had two miscarriages at about two months. She had dilatation and curettage following each one. At thirty she had had pneumonia and pleurisy on both sides. She had had frequent attacks of laryngitis, the last four months before admission. She was troubled with vague pains which she called "rheumatism." She had occasional frontal headaches. All her teeth were extracted ten years before admission because of pyorrhea. For six months her appetite had

been poor. She had much gas. She reached the menopause seven years before admission. She had no discharge from that time until three weeks before admission, when she had a small amount of brownish discharge lasting three days. She had some vertigo when she was tired. Twice she had fainted, not recently. Sometimes she had pains about the knees, but no real shooting pains. She was very tired at the end of her day's work. Nevertheless she did some work at home in the evenings. She felt constantly tired and strained.

Clinical examination showed a well nourished woman with flushed face, breathing rapidly. Skin dry. Many brownish papules over the abdomen. Mucous membranes dry and reddened. Lips and oral mucous membrane encrusted. Tongue dry, much reddened. Pharynx inflamed. Chest expansion much limited. Lungs: impaired resonance, diminished breath sounds and a few medium crepitant inspiratory râles over both bases. Apex impulse of the heart felt 8.5 centimeters to the left of the midsternal line in the fourth interspace, two centimeters outside the midclavicular line; right border of dullness 3.5 centimeters to the right, supracardiac 5.5 centimeters. Sounds and action normal. A rough blowing systolic murmur over the whole precordium, best heard over the mitral area. A questionable presystolic rumble over the same area. Pulmonic second sound accentuated and reduplicated, although the aortic second sound was greater. Blood pressure 95/65, 134/80, 65/40. Artery walls only slightly thickened. Abdomen protuberant, distended and tympanitic. Shifting dullness in the flank suggesting a small amount of fluid. Liver edge felt two fingerbreadths below the right costal margin and four fingerbreadths below the xiphoid. Tenderness in the epigastrium. Spleen not felt. (There was difficulty in getting the patient into position.) Rectal examination negative except for external hemorrhoidal rosettes. Pelvic examination showed cystocele and rectocele. Cervix low, with slight erosion. Extremities, reflexes, fundi and pupillary reactions normal. Left pupil greater than right. Both slightly irregular.

Amount of urine normal when recorded. Urine cloudy at one of two examinations, specific gravity 1.010 to 1.016. At a two-hour test April 15 the specific gravity ranged from 1.012 to 1.016. All of seven specimens showed a slight trace of albumin. Two other specimens showed a very slight trace. Two specimens of sediment showed occasional leucocytes; one showed occasional fine granular casts, one was loaded with fine granular casts. Renal function less than 25 per cent. Blood: 17,300 to 11,750 leucocytes, polynuclears 91 per cent., reds and hemoglobin normal. Wassermann negative. April 12 non-protein nitrogen 99, creatinin 1.96, uric acid 8.88. April 13 non-protein nitrogen 60. April

15 non-protein nitrogen 70, creatinin 1.96, uric acid 12.20. Widal negative.

A portable X-ray plate showed the diaphragm high on both sides. It apparently moved on the right. The right costophrenic angle was clear. There was no definite evidence of consolidation. The left costophrenic angle was somewhat hazy and indistinct, possibly because of adhesions, possibly because of a very small amount of fluid.

Temperature 100.4° to 105°, rectal. Pulse 95 to 132, with a terminal rise to 182. Respirations 25 to 50.

Orders. April 12. Fluids ad libitum. Soft solid diet. Individual precautions. Digitalis 3 grains daily. Morphia sulphate 1/6 grain at midnight. April 13. Digitalis 6 grains at once and a grain and a half at 10 p. m. Morphia 1/12 grain s.c. at once and every three hours p.r.n. Hot stupe and rectal tube. April 15. Digitalis a grain and a half daily. Morphia 1/12 grain s.c. One ampule pituitrin at 1 and 6 p. m. Force fluids. Special care of mouth. Caffein 10 grains s.c. every hour p.r.n. for collapse. (Not given.) Digifolin 2 ampules intramuscularly at 8.30 p. m. Turpentine stupe and rectal tube. Half a grain of codeia after stupe and every three hours for restlessness or cough. Chloral 15 grains immediately. If not effectual in one hour, paraldehyde one dram by mouth. April 16. Physostigmin 1/50 grain s.c. Pituitrin one capsule. Alcohol sponges. Caffein sodium salicylate. Digifolin one ampule. April 17. Morphia grain 1/4. Caffein sodium salicylate grains 15. Digifolin 3 grains intramuscularly.

The day after admission the patient was somewhat better. A surgical consultant thought there was no mechanical cause for the abdominal distension and advised enemas and turpentine stupes. An electrocardiogram showed normal rhythm, rate 110, P-R interval .2 seconds; left axis deviation. April 15 there were signs of hypostatic pneumonia. A heart consultant noted a harsh systolic murmur at the apex and the aortic area, the heart action rapid and weak. He was unable to make a diagnosis. April 16 eight ounces of blood was withdrawn from the right arm. A neurological consultant found no evidence of aphasia and no paralysis. The pupils were very small but reacted to light. There was some exophoria. The left fundus showed a clean-cut disc, engorged dark veins, no exudate. He found bilateral Babinski. He saw no evidence for cerebral accident or encephalitis.

All treatment failed to have any marked effect on the distension. April 17 the patient died.

DISCUSSION

BY RICHARD C. CABOT, M.D.

NOTES ON THE HISTORY

1. We distinguish between the sensation of chilliness which we all have when we have a cold

with a little fever, and the real shaking chill.

2. Dyspnea, apparently, was not here in the beginning.

3. Guesses and snap diagnoses are in order at the outset. One might easily think of subacute bacterial endocarditis with fever, and at the end, just before she came here, dyspnea. There are many other possibilities. The whole trouble might be pneumonia. I have seen a typhoid start with a chill, though it usually does not. It might be septicemia, malaria, meningitis. I think guessing is a good thing so long as we keep all the possibilities in mind.

4. Her father's "rheumatism" does not mean anything, as we don't know what kind of rheumatism it was.

5. They assume that her pneumonia and pleurisy were simultaneous, in other words that she had pneumonia, which always brings pleurisy with it.

6. This is a rather early menopause.

7. The second long paragraph is the result of questions asked, not merely of writing down what the patient complained of, but of following up the different systems of the body. I think the whole paragraph means nothing here. I do not see anything to help us to guess what is coming.

NOTES ON THE PHYSICAL EXAMINATION

1. Because of fever the condition of the lips and mucous membrane is of no diagnostic value.

2. The lung examination tells us very little. A person who has been sick with any infection will breathe shallowly, will have a high diaphragm, basal râles and dullness without necessarily any trouble at all in the lungs.

3. These measurements should mean an enlarged heart, because of the enlargement outside the midclavicular line.

4. The last blood pressure measurement was presumably taken near death.

5. This condition of the abdomen is enough to explain the signs in the lungs. That would push up the diaphragm and give all the signs.

6. The pelvic examination means nothing in particular.

7. There is a rather narrow margin of variation in the gravity of the urine. It is certainly a restricted variation. The renal function is first-rate, an unusually large amount for a patient as sick as this woman; so that does not help us at all.

The non-protein nitrogen is distinctly increased, three times at least what it should be. The creatinin is slightly increased, the uric acid a good deal increased. The uric acid is still the chief thing increased in the subsequent examinations.

8. We can be sure that they are having trouble with this diagnosis, because they are having the portable X-ray machine brought up into the ward.

9. There is no fluid in the pleura. They are thinking of pneumonia, but they cannot find it, and if the X-ray cannot find pneumonia we cannot certainly.

From the X-ray plates I should have said that both costophrenic angles were somewhat indistinct, but that the lungs were all right, that the heart did not show much enlargement. Of course the patient is so sick that she breathes while the plate is being taken. We can never get a very satisfactory plate when the patient breathes, and we get all this cloudiness instead of the sharp margin which we ought to get.

10. The chart shows a fever never less than 100°, continuous, progressive fever. What can it be? Pneumonia will do exactly that. Meningitis will do exactly that, a rapidly fatal typhoid, septicemia from any organism, peritonitis. There are many less common diseases that would do it. It is not characteristic of anything. The pulse is always high and the respiration always high, though higher and higher as time goes on. The chart shows then a steady febrile progression and nothing else.

11. We look through the orders to see if we can get any idea of diagnosis from the things they gave the patient. Pituitrin generally means getting near the end. We are trying almost anything. Those are mostly cardiac medicines. The physostigmin was probably used for abdominal distension which she had in the beginning.

12. The P-R interval is normal. There is a rather big left ventricle.

13. A PHYSICIAN: Was there a blood culture?

MISS PAINTER: There was.

14. DR. CABOT: "Exophoria" means the eye tending to drift outward. The Babinski is about the first definite sign that anybody has found, except an enlarged heart. Bilateral Babinski would tend to make us think there was some organic or cord disease. They have not yet tapped the spinal cord. I should think they would have.

A PHYSICIAN: Did they have a Wassermann?

DR. CABOT: The Wassermann was negative.

DIFFERENTIAL DIAGNOSIS

I do not believe this is pneumonia. They had X-rays at a time when it would have shown if it had been there. I do not believe it is meningitis. They certainly should have got more neck and cerebral symptoms generally. Why they did not do a lumbar puncture and rule it out I do not know. I do not believe it is typhoid. The pulse is high. The patient died very quickly. The onset is not right. We have none of the characteristic evidence of typhoid,—low white count and a positive Widal or positive culture in ninety-seven out of a hundred cases.

Can we rule out general peritonitis? I do

not see how we can. Of course we should expect to hear more about pain and tenderness. We do not hear anything of those very constant symptoms of peritonitis. And then the bowel movements,—how about those? We do not hear of paralysis of the bowel or that any movements occurred.

MISS PAINTER: There is no stool examination and no record of dejecta.

A PHYSICIAN: She had diarrhea and pain before she entered the hospital.

DR. CABOT: I do not believe there was complete obstipation or we should have heard more about it. But I do not see how we can still rule out general peritonitis. If we have general peritonitis we have to say, Where does it come from? and we have to answer that some cases of peritonitis, like some cases of pleurisy, are apparently blood-borne or lymph-borne, and come without perforation of any organ. This might be, therefore, a so-called blood-borne peritonitis.

A PHYSICIAN: Hasn't the patient been sick too long for peritonitis? She has been sick two weeks.

DR. CABOT: She may not have had it all this time. I think you are right however.

Typhus fever we ought to consider.

A PHYSICIAN: Wouldn't she be likely to have more delirium?

DR. CABOT: Yes, and more eye symptoms, conjunctivitis or other, and usually a rash. The white count would be high. Abdominal distension is not a common condition in typhus.

Of course malaria, which can cause a fever like this, is ruled out by the blood examination.

A PHYSICIAN: Do they ever have appendicitis without pain?

DR. CABOT: Yes, if it gets to peritonitis very quickly.

A PHYSICIAN: Would a paralytic ileus explain the pain?

DR. CABOT: Yes, I should say so. Of course we have not as accurate a knowledge of the bowel movements as we should like.

We cannot rule out malignant endocarditis. We have enlargement of the heart, we have a cardiac murmur, we do not know that we have not a positive blood culture, and we do not need to have evidence of embolism.

A PHYSICIAN: On admission there were some brown spots.

DR. CABOT: Yes, but they won't do for embolism. They have to be red, and we ought to have some new ones.

A PHYSICIAN: Can it be of as short a duration as this?

DR. CABOT: Yes, it could run as short a course as this, but I should be a little surprised. Of course she may have had it longer than we know.

A PHYSICIAN: Would it be a mesenteric thrombosis?

DR. CABOT: My point against that is the

same as against the other intestinal obstructions. The abdominal symptoms do not seem extreme or stormy enough, and again, there were no holes cut in the abdomen.

A PHYSICIAN: Were there any gynecological findings?

DR. CABOT: They were I should say negative, that is, what we find in very many women after the child-bearing stage. So I should not put any stress on those.

Streptococcus septicemia can give exactly this picture without any point of entrance known, with no lesion found anywhere in the body, pure streptococcus septicemia. Staphylococcus septicemia can do it. Pneumococcus septicemia can do it. Those are the commonest, and I do not see how one of those can possibly be excluded.

A PHYSICIAN: How do you explain the diarrhea?

DR. CABOT: There is no evidence that she had diarrhea here.

A PHYSICIAN: "She was awakened by a chill." Can you rely on that statement?

DR. CABOT: I think so. Of course that does not tell us anything except that she had an infectious disease. I admit she had an infectious disease, but I should like to say something more definite.

A PHYSICIAN: Tuberculosis?

DR. CABOT: We have not considered tuberculosis here, and we ought to. Why shouldn't she have milary tuberculosis? A high white count is against it but does not rule it out.

A PHYSICIAN: The X-ray didn't show it.

DR. CABOT: That is more against it. They ought to have backed it up by X-ray, but of course the patient is pretty sick, and without a better plate we do not always pick up milary tuberculosis. Still I should say these X-ray plates, so far as I know anything about it, are against it, are against milary tuberculosis. I am willing to bet against it.

A PHYSICIAN: Tuberculous peritonitis?

DR. CABOT: No, it is too quick. They run a long course.

A PHYSICIAN: Nephritis?

DR. CABOT: Can this be a chronic nephritis? She had high uric acid. She had pretty good kidney function, but a limited gravity and retention. Of course nephritis cannot cause this termination. This is not the termination of a case of nephritis unless complicated. But nephritis often is complicated by infections, by some of the infections we have been mentioning. If we say nephritis plus streptococcus septicemia or plus malignant endocarditis, that will do very well.

A PHYSICIAN: Would you consider a patient fifty years old with twenty-five per cent. renal function a good operative risk for prostatectomy in a male?

DR. CABOT: Yes, if other things were not more unfavorable than that, I should. The amount of urine was normal when recorded. It certainly had a fixed specific gravity on the only test they took. It had albumin every time. It had sediment all right for nephritis and all right for no nephritis. It had rather high non-protein nitrogen, not so high as most cases of nephritis. It had distinctly high uric acid. It had a normal renal function. The nervous symptoms ordinarily called uremia she certainly did not have. The blood pressure is against that. But she could have a low grade of nephritis, not very advanced, with a terminal septicemia.

A PHYSICIAN: As a cause of death nephritis would not have anything to do with it?

DR. CABOT: No, but its predisposing cause, the immediate cause infection, probably general septicemia.

A PHYSICIAN: Could she have had liver abscess primary to her peritonitis?

DR. CABOT: Liver abscess rarely breaks into the peritoneum. It is rare in this part of the world anyway except as a complication of gall-bladder disease. I should say we could rule it out on the history and the X-ray.

A PHYSICIAN: Is it too short a course?

DR. CABOT: Yes, but a great deal of the course of liver abscess is latent. That is as far as I can go. Now we might as well have the laboratory findings.

BACTERIOLOGICAL REPORT

Blood culture April 12 showed streptococcus hemolyticus in both flasks.

FURTHER DISCUSSION

DR. CABOT: Streptococcus hemolyticus comes most often with malignant endocarditis, but comes often without it. On the whole I still incline to doubt whether there is any endocarditis. The bleeding was done, Miss Painter says, because they thought she was uremic, and bleeding does sometimes help uremia.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Rheumatic heart disease.
Congestive failure.
Chronic nephritis.

DR. RICHARD C. CABOT'S DIAGNOSIS

Malignant endocarditis?
General septicemia?
General peritonitis.

ANATOMIC DIAGNOSES

1. Primary fatal lesion.

Acute vegetative endocarditis (streptococcus hemolyticus).

2. *Secondary or terminal lesions.*

Rheumatic heart disease, aortic and mitral stenosis (slight).

Abscess of the heart.

Septic infarction of the spleen with rupture.

Septic infarction of kidneys.

Acute intracapillary glomerulonephritis.

General peritonitis.

DR. MALLORY: This is an interesting case, because I think almost all the diagnoses are right except for tuberculosis. She did have septicemia with the streptococcus hemolyticus. There was no evidence as to where that infection started. It had settled on her heart valves, the mitral and aortic both, which showed old rheumatic deformities. The vegetations were rather small, but had been large enough to allow emboli to break loose. Whether any of these went to the brain or not we do not know, as we were not allowed to examine the head. They had, however, passed to the spleen and to the kidneys. These emboli were of course septic in type, and the ones in the spleen had caused the formation of large abscesses, one of which perforated into the peritoneum, giving a general peritonitis. There were two septic infarcts in the kidney, and also general acute intracapillary glomerulonephritis. There was nothing in the lungs beyond atelectasis.

DR. CABOT: Would your guess be that this started as a blood infection and then got implanted on the heart valves?

DR. MALLORY: I should be inclined to think so. I was not able to decide anything definite as to the mode of infection. At the time of necropsy I thought that the uterus was a little suspicious, but I think that the patient's age rules that out. The cervix was very large, and there was some hemorrhage of the endometrium, which is relatively uncommon in women who have passed the menopause, without cancer or some such cause. But that was the only suggestion we could get.

DR. CABOT: I understand that this was not a nephritis with a terminal septicemia, but a chronic septicemia with a terminal nephritis.

A PHYSICIAN: The findings before death were not those of acute nephritis.

DR. MALLORY: One possibility is that no record was made of red cells in the urine sediment, because she was bleeding from the vagina at the time. I think that a catheter specimen in any case in which we suspect vegetative endocarditis is one of the most important things we can do. It will usually show red cells.

There are only two ways in which we get general peritonitis in a case of malignant endocarditis. One is the rupture of an infarct of the spleen and the other is embolus lodging in a mesenteric vessel.

CASE 13402

COUGH AND LOSS OF WEIGHT

MEDICAL DEPARTMENT

A married Italian woman fifty-three years old entered the hospital for the first time January 8, fourteen months before her final admission. She was sent in for study of cough and loss of strength and weight. In spite of considerable language difficulty the history was believed to be fairly reliable.

Until a year before admission she was strong and fat, although she had had yearly attacks of bronchitis since the influenza epidemic in 1918. A year before admission on starting to go upstairs she became dizzy and fainted for a few minutes. During that winter she did not feel so well as usual. In April, after having some teeth pulled, she had prolonged bleeding. She dated a marked loss of weight from that time. During the summer weakness and emaciation became evident. She coughed, at times raising a little white sticky sputum, never blood. Three weeks before admission she became feverish and weak and had chills and headache for two days. She remained in bed two weeks, and had nosebleeds once or twice a day for a week brought on she thought by cough. Jaundice was noticed. She had marked frequency of urination, voiding very little dark bloody and cloudy urine. She had numbness and tingling in the fingers. At this time headache was infrequent and not severe.

One sister died of hemorrhage of unknown cause. The patient's second husband had had a chancre.

Until the present illness she had always been very strong, although she had very severe headaches in early womanhood from "chronic catarrh." She had one child and one miscarriage by her first marriage. She had been married twenty years to her second husband and had had no pregnancies. She passed the menopause three years before admission. At that time she had hot flashes associated with fainting and dizziness. Three years before admission she weighed 158 pounds.

Clinical examination showed a woman weighing 123½ pounds. Slight icterus of the sclerae and skin. Many teeth capped, some missing. Pyorrhea. Heart not enlarged, sounds of fair quality, a soft systolic murmur at the apex, a middiastolic and a rough systolic at the aortic area. A few râles at the bases of both lungs. Liver dullness from the fifth interspace; edge palpable 8 to 10 centimeters below the costal margin, hard, not tender, with a suggestion of roughness. Extremities showed marked varicosities. Pelvic examination negative except for slight erosion of cervix and a little blood in the os after examination.

Urine normal in amount, cloudy and dark at

2 of 4 examinations, specific gravity 1.014 to 1.022. Sediment loaded with leucocytes once, with epithelial cells twice, with squamous cells once, 2 to 4 leucocytes per high power field once. No albumin or sugar. Blood: 13,800 to 10,000; leucocytes, 89 per cent. polynuclears, hemoglobin 60 to 65 per cent., reds 3,650,000 to 4,032,000, slight microcytosis, moderate achromia. Icterus index 25 to 30. Van den Bergh test: direct slightly positive, indirect strongly positive. Non-protein nitrogen 36 milligrams. Bleeding time $3\frac{1}{2}$ minutes. Clotting time 16 to 20 minutes, with calcium chloride 15 minutes. Three Wassermanns strongly positive. Stools: guaiac positive at 3 of 8 examinations, twice strongly positive, macroscopic blood once.

X-ray. January 11 a barium meal and a barium enema showed no definite evidence of pathology in the gastro-intestinal tract. The diaphragm was high on both sides and the respiratory movements were limited on the right. The heart lay horizontal in the chest. The supracardiac dullness was somewhat increased. The lung fields were of normal brilliancy.

The patient was given a course of potassium iodide to which mercury was later added. The liver did not become markedly smaller. She gained six pounds and a half. February 9 she was discharged.

During the next six months she was given good antilutetic treatment and made satisfactory progress. In July she entered another hospital, where she was treated for a month for relief of abdominal swelling, epistaxis and bleeding of the gums. The abdomen was not tapped. Since July she had had no antilutetic therapy. For four months before her readmission her ascites and edema of the feet had been gradually increasing. As nearly as could be learned she had had no nausea or vomiting and had felt fairly well.

December 28, eleven months after her discharge, she entered the hospital for the second time.

Clinical examination was not complete or satisfactory because of the enormous ascites. She was poorly developed, emaciated and jaundiced, lying flat on her back, with a very large abdominal mass. Right upper eyelid thick and red. A splotch on the right cheek. Healing furuncles of the left wrist. All the teeth false. Chest expansion poor. Breathing slightly shallow. Râles at both bases posteriorly. Diaphragm somewhat high. A few crackling râles in both axillae. In the right back from the midscapula to the level of the angle of the scapula dullness, diminished breathing and crackling râles; tactile fremitus present. Apex impulse of the heart felt in the fifth space. Left border of dullness 9.5 centimeters to the left, a centimeter and a half outside the mid-clavicular line. No other enlargement to percussion. An apical systolic murmur; no dia-

stolic. Sounds and action normal. Blood pressure 120/70. Artery walls extremely thickened and tortuous. Marked dilatation of the veins over the abdomen and in the neck. An immense amount of ascites. Edema from the thighs to the toes. A rosette of hemorrhoids.

Urine normal in amount, specific gravity 1.012 to 1.030, cloudy at 4 of 11 examinations, dark at 4, alkaline at 3, the slightest possible trace of albumin at 6, the slightest possible trace of sugar at 3, bile at 7. A catheter specimen showed albumin, bile, negative sediment and two sterile cultures. Blood: 7,100 to 12,100 leucocytes, polynuclears 77 to 74 per cent., hemoglobin 50 to 70 per cent., reds 1,990,000 to 3,450,000. Two smears showed marked to moderate achromia and slight anisocytosis, platelets reduced. Non-protein nitrogen 31 milligrams. Icterus index 20 December 28, 8 to 10 January 25. Reticulated cells 0.2 per cent. Blood sugar 111. Wassermann strongly positive.

Temperature 97.5° to 101° after January 10 only once above 99.6° . Pulse 72 to 100. Respiration not remarkable.

The day after admission abdominal paracentesis was done with withdrawal of 12,000 cubic centimeters of golden yellow fluid with a slight bile tinge to the foam; specific gravity 1.014, 1500 red blood cells, 500 leucocytes. Of 15 cells seen in the smear all were lymphocytes; no organisms; three cultures sterile. After the tap a very hard liver was felt with two large slightly tender nodules extending to the level of the umbilicus. The spleen was not felt, though fingers were introduced three or four inches up under the costal margin. By January 1 the patient had reaccumulated almost all of the ascites and again felt miserable. A surgical consultant was unwilling to advise any surgical procedure. January 10 another tap was done and 9,000 cubic centimeters of fluid removed but not examined. An attempt was made to see the liver with a thoracoscope, but bubbles made the procedure unsuccessful. The patient felt much better after the tap. The abdomen filled up again very rapidly, however.

January 10 she was started on ammonium chloride 3 grams t.i.d. and 1 cubic centimeter of novaserol intramuscularly. During the following week she gained 5 pounds and a small sloughing area appeared at the site of the intramuscular injection. January 20 a third tap was done with removal of 7,000 cubic centimeters of clear straw-colored fluid, specific gravity 1.012. The liver seemed possibly smaller, the lumps perhaps larger than before. There was great relief following the tap. January 31 another tap was done and 8,000 cubic centimeters of straw-colored fluid removed, specific gravity 1.008. The lumps in the liver edge now seemed definitely more prominent. February 5 the patient was discharged.

The fluid collected as before. At the end of

two weeks her physician did another tap. She had vomiting of material "black like lumps of blood," and passed black stools in considerable quantities. She was continually jaundiced, very hoarse, and cold. She raised much thick white sputum. Before each tap her legs were swollen. There was tenderness in the right upper quadrant.

March 4, a month after the last discharge, she came to the Emergency Ward, where an abdominal paracentesis halfway between the umbilicus and the symphysis gave 9 quarts of straw-colored fluid, specific gravity 1.010.

Clinical examination in the wards next day was essentially as before except for less jaundice and what was believed to be a third lump on the liver edge.

Urine turbid; bile at one of two examinations. Blood: leucocytes 6,000 to 8,600, hemoglobin 30 to 20 per cent., reds 1,850,000 to 1,530,000, no variation in size or shape; clumping of platelets. Wassermann strongly positive. Non-protein nitrogen 34 milligrams. One of two stools gave a very strongly positive guaiac.

Temperature 100° to 97.6°. Pulse 80 to 130. Respirations 18 to 30.

The patient suffered a good deal. Morphia was used liberally. March 10 she complained of pain over the heart. The rate was rapid. Within an hour she began to vomit blood, and during the next hour vomited about a quart. A little after midnight she died.

DISCUSSION

BY RICHARD C. CABOT, M.D.

NOTES ON THE HISTORY

There is quite a variety of symptoms here that do not easily shape themselves, as I read it through for the first time, into any particular grouping. She has lost weight. She has cough with sputum. She has had a feverish attack, jaundice, nosebleed, difficulty with the urinary tract and numbness in her fingers. I come to the physical examination with very vague ideas as to what is the matter.

NOTES ON PHYSICAL EXAMINATION

1. After reading the physical examination I should say that jaundice is the presenting symptom.

2. We know nothing about the way the specimens of urine were obtained. Nothing is said about a catheter, so that we do not need to pay much attention to the sediment. There is nothing remarkable in the urine.

3. In the presence of jaundice one feels dubious as to the meaning of those three positive Wassermanns, even though we have reason from the previous history to suspect syphilis.

I take it they made a diagnosis of syphilis. Just where they think it is I am not sure; pos-

sibly in the liver. On account of the jaundice, anemia and Wassermanns I take it they called it syphilis of the liver.

4. The examination was unsatisfactory because of the enormous ascites. Remember there was no evidence of ascites at first.

5. Before the second entry we have had a very great increase in the anemia.

6. The absence of a palpable spleen even though they had a good chance to feel it is an important point in the differential diagnosis.

DIFFERENTIAL DIAGNOSIS

I take it the diagnosis centers between two possibilities. What are those two? Cirrhosis of the liver and syphilis of the liver. Let us try to weigh the points on one side or the other. We have some reason to believe she has syphilis,—the positive Wassermanns and the fact that she is under antisyphilitic treatment. That seems to be the best evidence. She has never been pregnant in a long period of marriage with her second husband.

All the evidence, it seems to me, centers in the abdomen, not in the chest or in the nervous system or the extremities, not in the gastrointestinal tract except so far as that is involved in the portal stasis which we certainly must believe to be present. Coming down to the cause of portal stasis, she has blood in the feces, enormous ascites, and jaundice with distension of the abdominal veins. These lumps mentioned are distinctly more like syphilis than they are like cirrhosis. Syphilis cuts such deep swathes in the liver that pieces of it seem almost separated from the main part; and although I never felt them quite so distinctly as this, I have felt something like this in a liver proved to be syphilitic. If we call it cirrhosis I cannot account for the lumps. Cirrhosis almost invariably produces a big spleen. We have had a good chance to feel the spleen and we have not felt it. Syphilis also goes with big spleen in some cases, but not consistently. As for ascites, I have not seen enough cases of syphilis of the liver to be sure how often that is present or absent. I have seen several cases without it. It seems a little queer to me that she should have had such a tremendous ascites with syphilis of the liver. Then one comes back to a general point which I think is of considerable importance. The diagnosis of syphilis is almost never confirmed at necropsy. It makes no difference what evidence you have. When you have been mistaken about syphilis as a cause of death as often as I have in the past twenty years you will make the diagnosis still, but you will make it with considerable hesitation. The second point is, I do not know how often syphilis of the liver is associated with the vomiting of blood. I do not see why it should not be. Either cirrhosis or syphilis would account for the anemia. You can have an intense anemia

with either. The amount of jaundice could go with either trouble. We have no alcoholic history.

A STUDENT: Her physician said that the woman was accustomed to drinking wines quite frequently.

DR. CABOT: She was an Italian. Most Italians do drink wine. We do not ordinarily associate syphilis with wine drinking. If it were not for those lumps I certainly should say cirrhosis. What else might these lumps be? They might be feces in the intestine; but we should not expect them to stay in one spot so steadily. They could not all be explained by gall-bladder or by extra liver lobes.

A STUDENT: How about carcinoma?

DR. CABOT: Carcinoma I have never known with this clinical picture. You are right in bringing it up of course. She is at the cancer age. But would be a little strange, I think, for her to have carcinoma going on as long as this and not showing itself in other ways.

A STUDENT: How about carcinoma of the cervix?

DR. CABOT: You must take it that they did not think so. They may have been wrong, but it would have been a bad blunder. I should say that with the general traditions of technique here we have no reason to expect it.

A STUDENT: How about that increase in the size of the liver?

DR. CABOT: We have all sizes with cirrhosis, —big, normal, small.

A STUDENT: Why can't you call it syphilitic cirrhosis?

DR. CABOT: If I said syphilitic cirrhosis I should mean syphilis. When I say cirrhosis I mean the other kind.

A STUDENT: Does cirrhosis give jaundice so early, before the ascites?

DR. CABOT: About 30 or 40 per cent. of cases have jaundice early or late. I think there is no special time for it.

A STUDENT: It appeared about a year before the ascites.

ANOTHER STUDENT: In syphilis so far advanced wouldn't you feel the deep set-in scars instead of the nodules?

DR. CABOT: I do not see how.

A STUDENT: I was given the impression that you get lesions that give indentation rather than protrusion.

DR. CABOT: I am going to make the diagnosis of cirrhosis of the liver because it is common and because I am afraid of the diagnosis of syphilis. It is perfectly possible that it is syphilis. I feel more certain that it is not malignant disease. It is possible, but not nearly so probable.

A STUDENT: What type of cirrhosis?

DR. CABOT: Alcoholic.

A STUDENT: What do you suppose caused the high red cell count in the ascitic fluid?

DR. CABOT: I suppose they got a little blood in, perhaps wounded a vessel inside in tapping. I think we need pay no attention to that.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Luetic cirrhosis of the liver.
Secondary hemorrhage from esophageal varices.

DR. RICHARD C. CABOT'S DIAGNOSIS

Cirrhosis of the liver.
Esophageal varices with hemorrhage.
Ascites.

ANATOMIC DIAGNOSES

1. *Primary fatal lesion*

Toxic cirrhosis of the liver.

2. *Secondary or terminal lesions*

Esophageal varices.
Ascites.
Arteriosclerosis.

DR. TRACY B. MALLORY: Cirrhosis of the liver is the diagnosis here. The liver was small rather than large. It weighed only 1530 grams. At the time of post-mortem examination it extended only two centimeters below the costal border, and it did not have any large nodules on it. It was a finely granular, typically hob-nail liver, very pale, with great increase in the connective tissue and little islands of yellow liver cells dotted through it. The complete loss of the normal lobular structure, and the fine-grained granulations serve to rule out syphilis and infectious cirrhosis. None of the hyalin degeneration typical of alcoholic cases was present, and no pigment. By exclusion it must therefore be a toxic cirrhosis.

The only possible explanation for the masses felt in the liver was offered by the gall-bladder, which was rather distended. But it hardly seems that it would be uniformly distended at every examination, since there were no stones or other obstruction present. There was a very considerable development of collateral circulation. There were fresh fibrous adhesions all over the liver and spleen to the anterior surface of the diaphragm, with evident newly-formed veins running through them; also some dilatation of a few veins connecting the portal system with the stomach veins, and also a definite dilatation of the esophageal veins. At one point in the esophagus was a small rupture about the size of the head of a pin. We could just pass a probe through it. That undoubtedly accounted for her terminal severe hemorrhage and death.

DR. CABOT: Isn't it unusual to be able to find these ruptures?

DR. MALLORY: Yes, it is. We never feel quite sure that we may not have caused the rupture

in opening the esophagus. But we had been very careful in this case.

The heart was entirely negative except for a very slight sclerosis at the base of the aortic cusps.

The spleen weighed 330 grams. That is about twice the normal size,—just at the border-line of palpability.

The other organs were all entirely negative.

DR. CABOT: I think you will remember from this case the dangers of making a diagnosis of syphilis of the liver, or any other kind of syphilis as a cause of death. You will not have a much better chance to make a right diagnosis of syphilis. Your experience will pile up as time goes on, and you will decide that it is better not to make a diagnosis of syphilis at the end of life, because usually the pathologist will not give you any support at all in that diagnosis.

Just a word about those lumps. You can see from the history that the people in charge of the case had the diagnosis of syphilis in their minds. They pictured in their minds what the syphilitic liver ought to be like, and they went after it, and they were successful. I cannot help thinking of the fact that they were so wise and knew their pathology so well that their fingers were unusually sensitive.

I do not think the wines had anything to do with it. I never knew a case of cirrhosis from wines alone. I think it took something else.

DR. MALLORY: There is a province in the western part of France where wine is the only beverage consumed, yet cirrhosis is extremely common, and that is sometimes used as evidence that it is not alcohol itself but some one of the chemicals that liquor contains that is the cause of alcoholic cirrhosis.

DR. CABOT: There was no evidence of aortic involvement?

DR. MALLORY: None at all.

DR. CABOT: Just another word about syphilis of the liver. Syphilis of the liver, so far as I can remember, has never been a cause of death. I have seen it a number of times, but it has always been found post-mortem with a number of other lesions,—never in itself a cause of death. I do not know the literature on the subject.

DEPARTMENT OF COMMERCE WASHINGTON

CENSUS OF INSTITUTIONS: 1926

Prisons and Reformatories—31 States' Preliminary Reports

WASHINGTON, D. C., September 28, 1927.—The Department of Commerce makes the following preliminary announcement of the results of the census of state prisons and reformatories for 1926.

Complete returns have been received from 31

states, covering 58 out of a total of 99 prisons and reformatories which are included in the census. These 58 institutions had a total of 27,018 prisoners received from the courts during the year 1926, as compared with 21,054 in 1923, or an increase of 28.3 per cent.

For the 31 states represented, there were 34.1 prisoners received per 100,000 of the general population, as compared with 27.9 per 100,000 received in 1923. In other words, the number of prison admissions has increased much more rapidly than the general population.

In comparing the figures for individual states, it should be noted that the number of prisoners committed annually to the prisons and reformatories in a given state is affected, not only by the prevalence of crime in the state, but also by such factors as the character and effectiveness of the local policies and machinery for law enforcement. Where a state shows a large increase in the number of admissions, or in the number of prisoners in confinement at a given time, such increase may represent an increase in the severity of the penalties imposed by the local courts, or in the percentage of offenders who are arrested and imprisoned, rather than an increase in crime.

The extent of the state penal institutions in each state is measured approximately by the number of prisoners present on a given date. In the 31 states covered by this statement, there has been a steady increase in the number of prisoners in state prisons and reformatories, as indicated by the figures for the dates at the beginning of the three most recent years for which data are available, which are as follows: January 1, 1923, 47,573; January 1, 1926, 59,692; and January 1, 1927, 63,828. The number of prisoners in confinement per 100,000 of the general population, increased from 66.6 on January 1, 1923, to 84.1 on January 1, 1927. For the most part, also, the figures for the individual states show striking increases.

A MIS-STATEMENT

The Boston Herald in the issue of September 28, 1927, states among other assertions that Andreas F. Christian doing business as a physician is a graduate of the Harvard Medical School. The directory of the American Medical Association has been unable to find evidence that Andreas F. Christian ever graduated from a medical school. He attended courses at Tufts and Harvard Medical Schools but was never given a degree. He was registered by the Massachusetts Board before the legislature enacted that feature in our law which provides that applicants for examination must be graduates of a medical school. For many years the legislature refused to pass this law, although petitions and bills were submitted.

NEW HAMPSHIRE MEDICAL SOCIETY

The One Hundred and Thirty-Sixth Annual Meeting of the New Hampshire Medical Society

HOTEL WENTWORTH, NEW CASTLE, N. H.

WEDNESDAY AND THURSDAY, JUNE 22, 23, 1927

OFFICERS FOR 1927

President: Emery M. Fitch, Claremont.
Vice-President: Joseph J. Cobb, Berlin.
Secretary-Treasurer: D. E. Sullivan, Concord.

Councillors:

Abram W. Mitchell, Rockingham County.
Harry O. Chesley, Strafford County.
H. H. Marks, Coos County.
F. E. Clow, Carroll County.
Clifton S. Abbott, Belknap County.
George W. Weymouth, Grafton County.
A. A. Pratte, Cheshire County.
Emery M. Fitch, Sullivan County.
Henry H. Amsden, Merrimack County.
George C. Wilkins, Hillsborough County.

Trustees:

Alpha H. Harriman, Laconia.
Ira J. Prouty, Keene.
Thomas W. Luce, Portsmouth.

House of Delegates:

Speaker, Fred E. Clow, Wolfeboro.
Vice-Speaker, Elmer H. Carleton, Hanover.

HOUSE OF DELEGATES

The President of the Society, ex-officio.
The Vice-President of the Society, ex-officio.
The Secretary-Treasurer of the Society, ex-officio.

ROCKINGHAM COUNTY

Samuel T. Ladd, Portsmouth.
Thomas W. Luce, Portsmouth.

MERRIMACK COUNTY

Harold J. Connor, Concord.
William P. Clough, New London.

CHESHIRE COUNTY

Osman H. Hubbard, Keene.
Frank Dinsmoor, Keene.

GRAFTON COUNTY

J. F. Gile, Hanover.
Frank E. Spear, Woodsville.

SULLIVAN COUNTY

Burton D. Thorpe, Newport.
Henry C. Sanders, Jr., Claremont.

HILLSBOROUGH COUNTY

F. P. Scribner, Manchester.
T. F. Rock, Nashua.
H. O. Smith, Hudson.

BELKNAP COUNTY

R. W. Robinson, Laconia.
R. W. Tuttle, Alton.

CARROLL COUNTY

Fred E. Clow, Wolfeboro.
B. Frank Horne, Conway.

STRAFFORD COUNTY

E. C. Batchelder, Dover.
D. L. Stokes, Rochester.

COOS COUNTY

Henry M. Wiggin, Whitefield.
Lewis C. Aldrich, Jefferson.

Delegate to the American Medical Association:
D. E. Sullivan, Concord.
Alternate: David W. Parker, Manchester.

Delegate to Council on Medical Education and Hospitals, A. M. A.:
George C. Wilkins, Manchester.

Delegate to Bureau of Health and Public Instruction, A. M. A.:
Howard A. Streeter, Manchester.

Anniversary Chairman:

Robert H. Brooks, Claremont.

Necrologist:

George H. Clarke, Concord.

STANDING COMMITTEES

1—PUBLIC POLICY AND LEGISLATION

Charles Duncan, Concord.
John H. Neal, Portsmouth.
Frank E. Kittredge, Nashua.
President, Secretary-Treasurer ex-officio.

2—SCIENTIFIC WORK

D. E. Sullivan, Concord.
R. H. Brooks, Claremont.
O. H. Hubbard, Keene.

3—COMMITTEE ON PUBLICATION

Secretary-Treasurer.
President.
Vice-President.

4—TUBERCULOSIS

R. B. Kerr, Manchester.
R. W. Deming, Glenciff.
Arthur Wallace, Manchester.

5—MENTAL HYGIENE

Charles H. Dolloff, Concord.
Benjamin W. Baker, Laconia.
S. B. Davis, Nashua.

6—CONTROL OF CANCER

F. E. Clow, Wolfeboro.
G. C. Wilkins, Manchester.
H. M. Kingsford, Hanover.

DELEGATES TO STATE SOCIETIES

Maine: Louis W. Flanders, Dover; H. H. Marks, Berlin.

Massachusetts: Ezra Jones, Manchester.

Vermont: L. B. Morrill, Center Harbor.

Rhode Island: D. G. Smith, Nashua.

Connecticut: F. W. Robinson, Laconia.

The Secretary was empowered to appoint an additional delegate and also a substitute delegate to attend the annual meeting of a state society if the attendance of the duly elected delegate should prove to be impossible.

A CALL FOR A MEETING OF THE HOUSE OF
DELEGATES

January 5, 1927.

*To the Members of the House of Delegates of the
New Hampshire Medical Society:*

The New Hampshire Medical Society has for an indefinite period of time been acting illegally under its Charter, as the present Charter now reads. A Committee was appointed at the last meeting of the House of Delegates to revise this Charter, and also to make recommendations for revision of the Constitution and By-Laws. In order to be effective the revised Charter must be passed by the New Hampshire Legislature. The Legislature is now in session, and will not meet again until 1929. It is, therefore, important that this revised Charter, as recommended by the Committee, be considered and acted upon by the House of Delegates, and then presented to the Legislature at this session.

Under the authority vested in me by the Constitution I do, therefore, call a meeting of the House of Delegates for Tuesday, January 18, at 11 A. M. in the Council Chambers, City Hall, Concord, N. H. At this meeting also will be presented for the consideration and action of this body:

First: The recommendations of the Committee on Revision of the Constitution and By-Laws;

Second: The approval of a participation of the New Hampshire Medical Society in an Association to be known as the "New England Medical Council."

Third: Any further business which may properly come before this meeting.

Signed:

DAVID W. PARKER, President.

HOUSE OF DELEGATES

MET IN CONCORD, N. H., JANUARY 18, 1927

THE meeting was called to order by the Speaker, Dr. Joseph J. Cobb. The President appointed Dr. D. G. McIvor alternate for Dr. Clough of Merrimack County and Dr. R. H. Brooks alternate for Dr. Thorpe of Sullivan County. It was voted that the report of the Committee on Credentials be postponed.

Dr. Harriman, Chairman of the Committee on Revision of Charter, Constitution and By Laws, in the nature of a preliminary report, read from the original charter the sections reading No. 1 "that all meetings shall be held in Concord or such other place in the State as the majority of members present shall judge fit." No. 2 "and also that the number of said Society who are inhabitants of this State shall not at any time be more than 70 or less than 15." The committee recommended that number 2 be expunged.

The committee recommended a basic unit of two members from each county to the House of Delegates and an additional member for each fifty members or major fraction thereof; giving to Rockingham, Belknap, Carroll, Coos and Cheshire Counties two each; Merrimack and Grafton three each; and Hillsborough five.

J. F. Gile and D. E. Sullivan were appointed

Committee on Credentials and reported a quorum.

Delegates present: H. J. Connor, Merrimack; D. G. McIvor, Merrimack; O. H. Hubbard, Cheshire; F. E. Spear, John F. Gile, Grafton; H. C. Sanders, Jr., Sullivan; F. N. Rogers, H. O. Smith, Hillsborough; L. B. Morrill, R. W. Robinson, Belknap; J. J. Cobb, Coos; R. H. Brooks, Sullivan; David W. Parker, President; D. E. Sullivan, Secretary-Treasurer; Thomas W. Luce, Rockingham.

It was voted that the New Hampshire Medical Society through its House of Delegates go on record as approving the formation of and participation in a New England Medical Council.

It was voted that the President appoint three delegates at large to the New England Medical Council—one for one year, one for two years and one for three years.

The Speaker leaving for his train requested Dr. Harriman to act as vice-speaker.

It was voted, on motion of Dr. Parker, that the charter as amended be referred to the Committee on Legislation with instructions to act before January 25th.

Voted that each county society elect an alternate for each delegate elected.

Voted to adjourn.

D. E. SULLIVAN,
Secretary-Treasurer.

THE HOUSE OF DELEGATES

MET AT THE WENTWORTH HOTEL, NEW CASTLE,
N. H., JUNE 21, 1927

MEETING called to order by the Speaker, Dr. Joseph J. Cobb, at 7:30 p. m.

The Secretary read the minutes of the special meeting held January 18, 1927. Dr. T. W. Luce mentioned that his name had been omitted from the list of delegates present at that meeting. Moved and seconded that the report be accepted as amended by recording Dr. Luce present.

THE SPEAKER: The Secretary has marked on the program "Remarks by Speaker." The remarks will be very brief, but there are one or two points I want to emphasize. This is a business meeting of the New Hampshire Medical Society. It is very important that the delegates be present at every meeting and be here promptly at the hours suggested. There is a large amount of business to be transacted and the Speaker hopes that every delegate will be in his chair at the appointed hour and that we will attend to the session with promptness. The only request I make is that you all be present and assist the Speaker in the progress of the business.

At this time I think it is as well to arrange for the different committees for the transaction

of the business, and I will appoint as Committee on Credentials

F. E. Spear, Grafton County
Frank Dinsmoor, Cheshire County
D. E. Sullivan, Secretary

Committee on Officers' Reports

S. T. Ladd, Rockingham County
Harold J. Connor, Merrimack County
R. W. Tuttle, Belknap County

Committee on Memorials and Communications

Fred E. Clow, Carroll County.
T. F. Rock, Hillsborough County.
J. F. Gile, Grafton County.

According to the By-laws, the Committee on Nominations, of five members, is to be selected by the House of Delegates.

It was moved that the Speaker appoint this committee. Seconded and carried.

The question was raised as to the propriety of having that committee appointed before the first day of the session.

The Speaker announced that he would appoint the same committee the next day so that there would be no question of its legality.

Committee on Nominations:

H. O. Smith, Hillsborough County
T. W. Luce, Rockingham County.
O. H. Hubbard, Cheshire County.
Burton D. Thorpe, Sullivan County.
B. W. Robinson, Belknap County.

The Speaker asked the Secretary to hand to the temporary chairman of each committee a list of appointees. The first appointee listed on these committees was designated to act as temporary chairman, and each committee was subsequently organized and elected its own chairman.

The Speaker asked each temporary chairman to call the committees together.

REPORT OF THE SECRETARY-TREASURER

I have the honor to submit the following report for the year 1926.

MEMBERSHIP

Our membership has not varied much in numbers during the past few years but has shown a gradual loss during the past ten years. However it gives evidence of greater tendency to increase at this time.

The advantages to a physician enrolled in the group of organized medicine are so apparent that one is at a loss to explain the indifference of some and objection of others to affiliate with their fellow practitioners in a compact body. Here is an opportunity first for the Councilors and then for the officers and individuals to work for the good of all. And that there may be sufficient time for the mature consideration of the many and varied problems at this very day in the minds of both profession and laity calling for our particular advice and action, the sessions of the House of Delegates should be so arranged that the Delegates could more leisurely and more thoroughly give full thought to those questions and demonstrate their capability and willingness to be leaders and jealous of their responsibility.

Members for 1926

Rockingham	42
Belknap	25
Carroll	8
Merrimack	67
Hillsborough	143
Sullivan	21
Strafford	31
Grafton	50
Coos	25
Cheshire	31
Not in County Societies	20
	463
Affiliated members	8
Honorary members	16
	487

COUNTY SOCIETIES

We depend entirely upon our constituent parts to make up the State Society and from the interest shown in their meetings of quality and quantity must come weal or woe to us in a large measure. Visits of the State officers to County meetings, especially by the President, have been inaugurated within recent years and have been very helpful and appreciated: such practices should be regarded as a duty and continued.

The failure of one county alone to function properly and promptly has a far-reaching effect for harm on all and this fact should stimulate every one of the ten societies to renewed efforts for betterment.

The President, in accordance with the vote of this House at the annual session appointed the following Committee on the Training and Distribution of Physicians in New Hampshire:

George C. Wilkins, Chairman, Manchester.
Louis W. Flanders, Dover.
Fred E. Clow, Wolfeboro.
Henry O. Smith, Hudson.
Charles Duncan, Concord.

FINANCIAL STATEMENT

Receipts

Balance January 1, 1926	\$49.60
Hillsborough County Dues	572.00
Merrimack " "	236.00
Grafton " "	212.00
Rockingham " "	176.00
Cheshire " "	149.00
Coos " "	120.00
Belknap " "	100.00
Sullivan " "	76.00
Carroll " "	44.00
Strafford " "	28.00
Members not in County Societies	96.00
Exhibitors	1380.00
Entertainment Committee	30.00
Banquet Tickets	570.00
	\$3838.60

Expenditures

February 11—Postage	\$4.00
April 3—Appropriation Cancer Committee	25.00
30—Bastian Brothers Badges	32.67
George R. Leavitt letterheads	4.50
May 1—Evans Printing Company, 1000 Programs	70.00
1—Postage	3.47
12—Carter & Co., Clasp Envelopes	14.55
19—Frances Barnard (Stenographer)	2.00
21—Trustees' Expenses	4.50
Refund Dr. McMillan	2.00
22—Trustees' Expenses Prize Essay	16.75

24—Frances Barnard (Stenographer).....	3.00
26—A. Perley Fitch, Banquet Candy.....	14.40
S. Warner & Co., Banquet Cigars.....	15.00
Refund Dr. Tuttle.....	3.00
29—Prescott Sign Co.....	66.73
Concord Police Department.....	37.50
600 1½ cent envelopes.....	10.16
June 1—C. Pellisier Co., 1 case.....	7.00
Eagle Hotel Co., Banquet.....	584.00
Central Delivery Co.....	3.00
Refund Dr. McMillan.....	6.00
Evans Printing Co.....	30.50
5—Refund Dr. D. G. Smith.....	12.00
7—500 2c Envelopes.....	10.99
Refund Dr. Geo. H. Parker.....	6.00
11—Dr. John F. Holmes, Correspondent.....	25.00
21—E. C. Eastman Co.....	1.50
24—G. L. Lincoln Co.....	6.75
28—Donald McLeod, Florist.....	40.50
Harry Owen, Clerk Meeting.....	8.00
Miss Sullivan, Clerk Meeting.....	8.00
29—Mabel E. Shaw, Stenographer.....	39.28
The Cofillons Orchestra.....	62.50
Expenses of Exhibit.....	740.32
Stationery and stamps.....	\$29.46
Printing.....	24.82
Typewriting.....	40.00
E. W. Abbott for carpentry and arranging exhibits.....	36.90
Refund on cancelled exhibit Auditorium.....	15.00
Trucking.....	4.25
E. C. Simpson, removing chairs from Auditorium, etc.....	55.00
Concord Wiring and Supply Bekdash Temple, chairs and tables.....	55.89
	29.00
	\$740.32
July 1—D. E. Sullivan, Salary and Clerk 6 mos.....	175.00
D. E. Sullivan, Expenses 6 mos.....	12.10
9—William H. Park, Expenses meeting.....	29.50
October 13—A. L. McMillan, Refund.....	2.00
21—King's Garage, Expenses meeting.....	17.50
December 11—400 8c stamps.....	32.00
29—F. C. Barnard.....	2.00
31—D. E. Sullivan, Salary and Clerk 6 mos.....	175.00
D. E. Sullivan, Expenses 6 mos.....	12.00
100 8c stamps.....	8.00
Trustees.....	750.00
Granite State Press, Transactions.....	652.33
	\$3788.00
Balance.....	50.60
	\$3838.60

At the special meeting held at Concord January 18, 1927, the President was authorized to appoint the delegates to the New England Medical Council, one to serve one year, one for two years and one for three years, and the appointment was made as follows:

Emory Fitch, Claremont, for one year.
George C. Wilkins, Manchester, for two years.
Thomas W. Luce, Portsmouth, for three years.

The annual conferences of the State Secretaries and Editors of State Journals have been recognized by the American Medical Association as valuable contributions to the higher ideals which it so forcefully represents and your Secretary had the pleasure and honor of presenting at the meeting held at Chicago last November a paper entitled "How can we secure closer cooperation of other professional organizations and the laity?"

D. E. SULLIVAN, *Secretary-Treasurer*.

This report was accepted and referred to the Committee on Officers' Reports.

REPORT OF THE COUNCIL

A meeting of the Councilors, New Hampshire Medical Society, was held on Thursday, June 23, at 2:15 P. M. Councilors present, G. C. Wilkins, F. E. Clow, H. O. Chesley, H. H. Amsden. Questions of medical ethics were discussed. It was voted that the Councilor in each district be informed about the Maine plan of medical defense and other matters which may be brought before the New England Medical Council, that they may convey such information to their respective societies at their meetings.

GEORGE C. WILKINS, *Chairman*.

H. H. AMSDEN, *Secretary*.

REPORT OF COUNCILORS

ROCKINGHAM COUNTY

The annual and only meeting of the Rockingham County Medical Society was held at Probate Court Room, Exeter, on October 14, 1926.

President Forrest J. Drury presided and Dr. Walter Tuttle, long our Secretary, filled his chair.

The program was both interesting and profitable. This included an address by Dr. David W. Parker, President State Medical Society. Dr. Edwin H. Place of Boston read a paper on Scarlet Fever and Dr. Robert L. Mason, also of Boston, one on Recent Developments in Gall Bladder Surgery.

Dr. John H. Holmes spoke on Infiltration Anaesthesia and exhibited some instruments for using the same.

Nearly every physician in the county is a member but due chiefly to geographic conditions the annual meeting seems to be the one practicable though more frequent ones would probably develop more literary work among the local members.

A. W. MITCHELL.

HILLSBOROUGH COUNTY

The two meetings of the Hillsborough County Medical Society were held in October at the Manchester Country Club, and the Spring meeting at the Nashua Country Club in April. Excellent luncheons were enjoyed at both these meetings and the scientific programs were attended by a large number of members. The papers were discussed freely. The two local societies in Manchester and Nashua have held their usual meetings throughout the year. The Manchester Medical Society as usual has held the majority of its meetings in the various hospitals of the city and the programs have combined clinical demonstrations with scientific papers. There are no other subsidiary or local societies in the county.

The Hillsborough County Medical Society numbers 141 members. During the year there have been 3 deaths. The deceased members were Guy H. Greeley of Merrimack, A. F. Wheat and J. E. Lemaitre of Manchester. Six new members were admitted during the year.

GEORGE C. WILKINS.

COOS COUNTY

The Coos County Medical Society has held two meetings since the last report; one at the Waumbec Hotel, Jefferson, last September which was honored by the presence of the State President, Dr. David W. Parker, and the State Secretary, Dr. D. E. Sullivan. Due to some misunderstanding the attendance was small. The second and last meeting at Whitefield May 23, '27, proved to be one of the most interesting and enjoyable of any held by the society for several years.

The newly organized Woman's Auxiliary as well as

physicians from Littleton, Twin Mountain and St. Johnsbury were guests of the society.

Forty-seven members and guests enjoyed a special lunch at the Lindsay Inn, after which all adjourned to the Morrison Hospital where the ladies were entertained by Mrs. Morrison.

Dr. Robert Mason of the Lahey Clinic of Boston gave an illustrated talk on the Diagnosis of Goitre and Dr. W. H. Leith of Lancaster gave a very interesting sketch of Prominent New Hampshire Physicians of Early Days. Eight new members were elected to membership.

The total membership is now 40, the largest in history. There have been no deaths or removals during the year.

The finances of the society are in splendid condition, officers and members are in harmony and prospects for the future are very encouraging.

HOMER H. MARKS.

CENTER DISTRICT AND MERRIMACK COUNTY

During the past year the Society has held four regular quarterly meetings. At the meeting in June, held at the Franklin Country Club, the speaker was Professor C. E. Bolser, of Dartmouth College, who read a paper on Chemistry and Modern Medicine. At the October meeting, held at Pembroke Sanitarium, the members of the Society were the guests of Dr. R. B. Kerr, and the speaker was Dr. E. O. Otis, of Boston, who spoke on Present-day Methods in Diagnosis and Treatment of Tuberculosis. The annual meeting was held at the Eagle Hotel, in Concord, Wed., Jan. 12. Dr. D. W. Parker, President of The N. H. Medical Society, gave a short address, and the paper of the day was given by Dr. J. H. Townsend, on Specific Preventive Measures in Diphtheria, Scarlet Fever and Measles. The April meeting was held at the Eagle Hotel, and the principal speaker was Dr. Paul Jepson of Boston, who spoke on The Commoner Fractures of the Upper Extremity. The meetings are generally well attended, the scientific papers of interest and value, but for most of us the fellowship of such gatherings is their best feature.

H. H. AMSDEN.

CARROLL COUNTY

One meeting of the Carroll County Society has been held this year, a successful meeting in that all present joined in lively discussion of topics of general interest.

A visiting physician, Dr. Fred B. Sanborn, of Long Island City, N. Y., gave an excellent address on "The Duties and Responsibilities of the Industrial Surgeon."

Officers were elected, while the members of the Woman's Auxiliary held forth in a nearby room.

FRED E. CLOW.

BELKNAP COUNTY

The Belknap County Medical Society held seven meetings during the last year, from October to April, inclusive, monthly.

The meetings were well attended, the papers read carefully prepared and valuable. The society gained two new members during the year.

The average attendance and interest is good. The society is in a most prosperous condition.

C. S. ARBOTT.

STRAFFORD COUNTY

The annual meeting of the County Society was held in January and the semi-annual meeting in September, both held in Dover.

The only other medical society in the County, the Dover Medical Society, held nine well-attended meetings.

There have been no happenings of importance during the year to report.

H. O. CHESLEY.

CHESHIRE COUNTY

The Cheshire County Medical Society held three meetings during the year 1925. The meetings were well attended, the papers carefully written and each paper was followed by a friendly and instructive discussion. The Society is very thankful to Miss Louise Thompson, Superintendent of the Elliot Community Hospital, for her kind and generous hospitality.

A. A. PRATTE.

SULLIVAN COUNTY

The Sullivan County Medical Society has held three meetings during the past year with a ninety percent attendance at each meeting. The society is very much alive at the present time, every doctor in the county is a member and the dues are fully paid.

EMERY M. FITCH.

These reports were referred to the Committee on Officers' Reports.

REPORT OF DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

The meeting this year was held May 16-20 in Washington, D. C., always attractive at this season of the year and noted for its many points of interest. The attendance was exceptionally gratifying, the scientific sessions and exhibits were of the usual high order and the occasion honored by an address by the President of the United States, Calvin Coolidge, at the installation of the President of the association, Dr. Jabez N. Jackson; and also by a reception on the White House grounds to the members and their guests.

Your delegate served on the Committee on Miscellaneous Business.

More than the ordinary amount of business came before the House necessitating an extra half day's work, but the delegates remained regularly at their duties and with the hearty coöperation of the officers and committees promptly and efficiently disposed of all matters.

The committee, of which your delegate was a member, to investigate the physical condition and financial status of incapacitated physicians, reported inexpedient at this time and referred the data gathered through its survey to the Board of Trustees with recommendations to continue the study of the matter in full and report at the next session.

A committee on the "Public Responsibility of the Profession" was elected and undoubtedly will have many important problems submitted to it for consideration.

The Board of Trustees was directed to present to Congress a bill providing for the removal of present restrictions on the therapeutic use of alcohol, applying such regulations as seemed wise and necessary.

Recognition of the value of the Woman's Auxiliary was taken in the request to have the Board of Trustees appoint a liaison committee between the Association and the Auxiliary.

Dr. William Sydney Thayer of Baltimore was elected President and Minneapolis chosen as the place for the 1928 session.

D. E. SULLIVAN.

Report referred to the Committee on Officers' Reports.

REPORT OF THE NECROLOGIST

Christopher Allen Sanborn, Redlands, California — Died July 18, 1925.

- Guy Hastings Greeley, Merrimack—Died May 30, 1926.
 Howard Wilfred Cleasby, Lancaster—Died July 1, 1926.
 John Duncan Quackenbos, New York City—Died August 1, 1926.
 Arthur Fitts Wheat, Manchester—Died August 11, 1926.
 Samuel Rice Upham, Claremont—Died October 12, 1926.
 Edmund Emerson Hill, Suncook—Died October 24, 1926.
 Joseph Edmond Lemaitre, Manchester—Died November 22, 1926.
 Nathan Leroy Griffin, New London—Died December 23, 1926.
 Elmer E. Dean, Lebanon—Died January 1, 1927.
 Edward Scanlan Sullivan, Concord—Died April 9, 1927.
 John Wheeler, Plymouth—Died June 5, 1927.

GEORGE H. CLARKE.

June 18, 1927.

REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

New legislation enacted during 1927 that concerned the medical profession in any way was embodied in only one or two bills and resolutions.

The chiropractors and League of Medical Freedom made an attempt to do away with the compulsory vaccination law for school attendance. After several hearings the bill was defeated in committee. The medical profession was well represented at these hearings and was responsible for speakers against any change in the law. A bill was presented to increase the pay of the Medical Examiners for reviewing cases of suspicious deaths. The bill passed the house, but was killed in the Senate on the "score of economy." Several workmen's compensation bills were presented to the legislature resulting finally in a so-called compromise law being agreed upon. However, it was of doubtful value too heavy for late digestion and died in the house after being presented by majority of committee.

A milk bill was passed to take effect July 1, 1928, requiring milk sold at hotels, lunch-rooms, etc., to be served from original containers.

A resolution to provide money for a proper solution of the cancer situation in the state was denied on the ground that \$30,000 could not be found available in the 1927 state budget. It had many sympathetic followers and will have a better chance of receiving support at the next session.

The Senate of the last legislature was not sympathetic to increasing, or even maintaining appropriations that had to do with the prevention and control of infectious diseases. Controversy over many matters was a twelfth hour affair, and after it was all over, a cut was made of \$10,000 for the care of tuberculous patients, and \$30,000 for the eradication of bovine tuberculosis. In fact, all appropriation increases for established departmental work in the various departments was denied.

CHARLES DUNCAN, *Chairman.*

The Report was referred to the Committee on Officers' Reports.

REPORT OF COMMITTEE ON SCIENTIFIC WORK

After some unavoidable delay, due to the failure to receive certain necessary information before issuing, the distribution of the programs for the meeting was a few days late. As printed and in the hands of the members it seems to present items of sufficient

interest and value to attract an unusually large attendance for the sessions.

The names of the members of the profession and others from neighboring states, well known throughout the country, give added enjoyment to that portion contributed so generously and so ably by our own membership.

A new feature is the exhibition of X Ray films by the different hospitals under the supervision of Dr. H. O. Chesley of Dover and it is hoped its approval will warrant its annual appearance.

D. E. SULLIVAN,
R. H. BROOKS,
O. H. HUBBARD.

This report was referred to Committee on Officers' Reports.

REPORT OF COMMITTEE ON PUBLICATION

Specifications for printing and binding the Transactions for 1926 were submitted to different firms and the contract was awarded to the Granite State Press of Manchester, the lowest bidders, at \$1.39 point plain per page; \$1.60 point plain per page printing and 24 cents per book for binding.

D. E. SULLIVAN,
D. W. PARKER,
EMERY FITCH.

Dr. F. E. Clow presented the following:

Proposal:

That the Trustees of the N. H. Medical Society shall use on orders of the Secretary-Treasurer, for one year, as an experiment, the funds, or such part as is necessary, from the income on the General Fund in the custody of the Trustees for the following purpose:

To send to each member of the N. H. Medical Society a monthly or bi-monthly Bulletin, printed or mimeographed, as seems best, this bulletin to contain such material as:

- News items affecting members.
- Notices from the office of the Secretary-Treasurer or other official.
- Reports of standing and special committees.
- Notices of county society meetings.
- Public Health notes.
- Legislative matters, bills introduced, etc.
- Notices of towns needing physicians.
- Notices from the board of registration as to candidates examined, licensed, etc.
- Special short articles by members dealing only with questions of ethics, policy, and economics.

Report of Committee on Proposal for Monthly Bulletin

We recommend that this proposal be rejected.

R. W. TUTTLE,
H. O. SMITH,
D. L. STOKES.

On motion duly made and seconded the report was accepted.

REPORT OF COMMITTEE ON CONTROL OF CANCER

- The work of your committee this year has been largely concerned with distribution of literature through the Home Demonstration workers of the University of New Hampshire. Through the generous coöperation of Miss Williamson we have been able to reach a class of women who can be reached in no other way.
- A member of the committee gave an address on Cancer at the meeting of the New England Public Health Association. Your chairman attended the International Symposium of Cancer at Lake Mohonk, N. Y., in September, 1926. The notable

achievements of the symposium were the discussion of the cancer problem as an international public health question which is being worked out in practically every civilized country in the world. Emphasis was laid on early diagnosis, the care of incurables, the organization of centers for treatment and research.

3. Your committee feels that the time is approaching when the State Board of Health should take over this work, acting as leader in the cancer movement, and that the society should offer to cooperate. The Society should not have to alone bear the work of the campaign, because the medical society, no matter how powerful, can never command the assistance of other bodies and federations to the same degree.
 4. There is no question in our minds that cancer presents a most pressing public health problem today. Its deaths are increasing in number in New Hampshire whether there is an increase from the biometric point of view or not. There is no question in our minds that physicians, through legitimate propaganda, by means of proper advice and early consultation with surgeons, can do much to help lower the mortality.
 5. We believe that the Committee on Public Policy and Legislation should foster any legislative measure leading to a hospital for incurables in this state.
 6. The remainder of our appropriation from 1925 was used to purchase for distribution the literature of the American Society for the Control of Cancer.
- We recommend that an appropriation of twenty dollars be granted the committee to continue its work.

FRED E. CLOW, *Chairman.*

Report referred to Committee on Officers' Reports.

Committee on Revision of the Constitution and By-Laws.

The Chairman, Dr. Harriman, made a comprehensive report submitting a number of amendments to the Constitution and By-Laws. This report was freely discussed by the members of the House of Delegates, as the Speaker stated, for the benefit of the Committee.

On motion of Dr. Ladd, a rising vote of thanks was extended to the Committee on Revision of the Constitution and By-Laws for the arduous work which they have performed, as they deserve much credit for the time and work they had put in on the matter.

Report of Committee on Medical Education and Distribution of Physicians.

DR. HARRIMAN: I am speaking for the committee as a whole. I wish to thank you for your kindness in offering to us a rising vote of thanks.

Resignation of Chancey Adams from the Board of Trustees.

June 22, 1927.

To the House of Delegates of the New Hampshire Med. Society,

D. E. Sullivan, M.D., Sec'y.

Dear Sirs:—

Kindly accept my resignation from the Board of Trustees.

Thanking you for the honor conferred upon me by electing me to membership of the Board.
I remain,

Yours truly,
CHANCEY ADAMS.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND DISTRIBUTION OF PHYSICIANS

PURPOSE AND REASONS FOR COMMITTEE

Realizing the gradual disappearance of physicians in the rural districts and the failure of recent graduates to enter the field of rural medicine, the House of Delegates of the New Hampshire Medical Society authorized this committee to make a study of the local situation, and to pursue whatever investigation they might choose in order to secure the necessary information with respect to the present situation and what may be expected in the future. The committee was instructed to embody the results of their investigations in a report to the New Hampshire Medical Society.

As the Dartmouth Medical School in the past has represented a source of supply of practicing physicians for the State, it was suggested to the House of Delegates that this committee consider what benefit the State of New Hampshire might anticipate from the reopening of the last two years of the school.

In the next decade the people of New Hampshire may awaken to a more deplorable condition than exists at the present time, and the organized medical profession should investigate now, be cognizant of facts, and endeavor to always be in a position to offer practical information which might aid in the solution of this difficult problem.

PRESENT DISTRIBUTION OF RURAL PHYSICIANS

In 1923 a comprehensive survey of the supply and distribution of physicians in New Hampshire was presented to the New Hampshire Medical Society by a committee headed by Dr. Frederick P. Lord of Hanover. In this survey it was shown that:

Of the 235 towns in New Hampshire 99 had no resident doctor. These 99 towns totaled a population of 41,156 inhabitants. The individual towns, however, averaged less than 500 population. Of the 99 towns without doctors 46 could reach medical care by traveling less than five miles.

In papers read before the medical society in 1921 and 1922, Dr. Lord discussed at length the situation at Dartmouth as well as the condition of medical practice throughout the State. He revealed a condition of affairs which merits study and further consideration. So thoroughly was the subject matter discussed from all angles by Dr. Lord, that the committee considered nothing could be gained by again covering the same ground. Those who are interested may study the papers and report in the published transactions of the New Hampshire Medical Society.

There has probably developed little change in the existing conditions during the past four years. The survey of Dr. William Allen Fusey in 1926, embracing as it did the entire country, demonstrates the same conditions existing in every State in the Union.

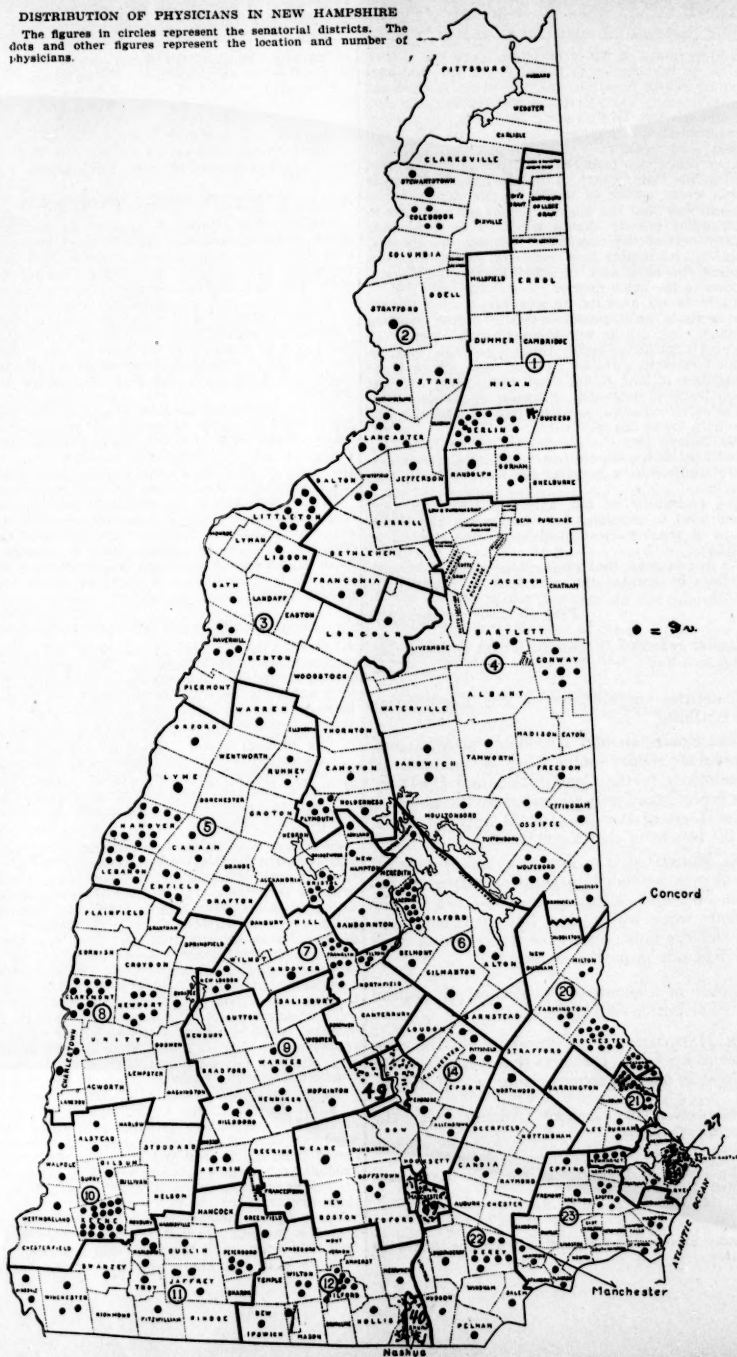
In 283 rural counties in 41 States the average age of physicians was found to be 52 years, and only 9% of the 4410 physicians practicing in these counties were graduates of the last ten years. A recently published table by Mayers and Harrison, shows that in 1906, 45% of recent graduates settled in towns of 2500 or less population, while in 1923, only 18% went to these smaller towns.

These figures demonstrate briefly but conclusively that the medical graduate of today does not look favorably upon small town or rural practice.

While it is true there are fewer graduates today

DISTRIBUTION OF PHYSICIANS IN NEW HAMPSHIRE

The figures in circles represent the senatorial districts. The dots and other figures represent the location and number of physicians.



than in 1906, the total number is still adequate to supply the needs of the country.

It is important to note that there is no organized effort on the part of the medical schools to aid in equalizing the distribution of physicians. The distribution from medical schools is inefficient and uneconomic and is dependent upon no method of co-operation nor upon the law of supply and demand.

Among the many reasons advanced for the urban drift, besides the general urban increase in population, are the reduction in the number of medical schools (166 to 79), the elevation of standards with lengthening of the course, increased cost of education, the tendency of schools to disregard the preparation of students for general practice and overemphasis on research and specialties.

The lack of social life and educational facilities for children, combined with economic conditions which would make it difficult to make a competent living, are factors which influence the graduate to look away from the smaller communities toward the larger. Physicians trained under present hospital methods do not desire practice where these facilities are not available. With the common use of more rapid methods of transportation, the rural population avails itself more frequently of the services of physicians in nearby cities.

The well-to-do, rural inhabitant, with the automobile and with good roads can obtain the services of physicians from the larger towns and cities. This condition is a potent factor in removing medical services from the less prosperous inhabitants of the rural districts, and medical service for this class is less easily available than formerly.

CHANGE IN CONDITIONS

While realizing the dearth of physicians in rural communities we must also recognize the changing conditions that make fewer physicians necessary in these communities. It must be borne in mind, however, that our concern is not only with present conditions, but for conditions as they may be in twenty years, when the 50 and 60 year old physicians are no longer active.

The trend of medical practice is being altered by the enormous growth of knowledge regarding the prevention of disease, by the control of communicable diseases, and other public health activities, by more outdoor life and better conditions of living, by better care of the eyes and teeth, by more rational feeding of babies, by the control of milk and water supplies and the disposal of sewage.

The growth of rapid methods of communication and transportation and the more recent tendency in this climate to keep main town roads and trunk lines open through the winter months, have widely increased the radius of individual practice.

A statute enacted by the legislature in 1925 enables towns to employ a physician. Since then five towns have offered financial inducements to a physician settling in the town, and three have obtained resident physicians in this way.

RELATION OF DARTMOUTH MEDICAL SCHOOL TO RURAL PRACTICE

In the minds of some of the members of the committee it was deemed possible to so control a certain number of graduates of Dartmouth Medical School by subsidies, through scholarships or otherwise, that they would be bound by agreement to give from three to five years' service in some rural district determined by the Board of Registration in Medicine, or by the College authorities. In the small State of New Hampshire it might be possible, by controlling a few graduates of each year's class, to supply the rural districts especially needing such service. It has been argued by some that the existence of a medical school in New Hampshire would not increase the

number of practitioners in New Hampshire. It seems logical to assume, however, that with a medical school in the State, more men in New Hampshire will study medicine, and some of these men will naturally gravitate toward localities having tangible relation to the school. This was true of Dartmouth graduates throughout the years of its activity as a complete school. It is significant that since the elimination of the last two years at Dartmouth Medical School, the largest number of young men entering practice in the smaller towns of New Hampshire are graduates of the University of Vermont, a school comparable in many ways to Dartmouth, and the only remaining small medical school in New England.

It is to be understood that any consideration of reopening the last two years of Dartmouth Medical School would presuppose its being conducted and accepted as a Class A School.

Through contact with officials of Dartmouth College and Dartmouth Medical School and by correspondence with the Educational Boards, medical education, the committee has been able to record the following facts, opinions and propositions:

The need for the development of an adequate medical personnel in Northern New England has become critical and urgent.

It is the purpose of Dartmouth College, both historically and in terms of the declared policy of the Trustees, to maintain the Medical School at its traditional high standard of efficiency and, when the requisite ways and means are made available, to give effect to the proposed restoration of the four-year course.

The desirability and feasibility of the project of resuming the four-year course, from the point of view of the Trustees, is mainly dependent upon the raising of the necessary funds without unduly interfering with the program for financing the principal work of the institution as an undergraduate college of liberal arts.

The teaching staff is loyal and interested.

The principal factor against establishing a four-year course is the lack of funds required for the erection of buildings, the equipment of the buildings, the enlargement of the hospital and the employment of full-time teachers.

The desirability of having a four-year medical school located and administered as a unit in a single spot is deemed so obvious and peremptory that while clinical material in Hanover may be limited to a certain degree, yet it can undoubtedly be extended to a point adequate for the proper intensive and thorough medical training of a four-year school, which would keep its numbers not above a point at which it could efficiently train the natural quota of students coming to it, who would then have the opportunity to study medicine in this State, and who after graduation tend naturally to mitigate the present unsatisfactory condition of medical supply in this State.

The supply of clinical material in Hanover is limited but if the medical school is to be revived it will be in Hanover and the proposition of having part of the work in Manchester will probably not be looked upon favorably. On the other hand Manchester is the only community in the State providing over 250 hospital beds. It is also centrally located between Concord and Nashua, each with approximately 200 hospital beds.

The State of New Hampshire does not contribute to the support of Dartmouth College and this was discontinued at the request of the Trustees. In all probability a State appropriation for the upkeep or development of the medical school would not be refused by the Trustees.

It is perhaps due to the fact that Dartmouth College as a whole is so urgently in need of money that neither the Trustees nor the president feel that it would be fair to make active motions toward obtaining money for the smaller part of the institution.

In all probability, if the funds for the reestablishment of the medical school came from without, no obstacles would be put in the way of developing the medical school and it might be heartily welcomed.

The only hopes of funds for reopening the medical school are apparently from two sources: 1st, State appropriation; 2nd, endowment; because: the General Educational Board which is financed by the Rockefeller Foundation has in the past definitely adopted the policy of development of large medical centers in different parts of the United States and is committed to the upbuilding of these centers, and the possibility of this board contributing money for the support of a small school is very unlikely. During the last few years however, through the attitude of the profession, of the general public, and possibly by the Board itself, there has been a partial deviation of that policy toward a belief in the necessity for the development of smaller centers.

Dartmouth Medical School has been voted into the membership of the American Association of Medical Colleges and the investigator stated that Dartmouth is one of the best two-year schools of medicine he had seen.

Inquiries directed to the Rockefeller Foundation and the General Educational Board produced nothing suggestive, instructive, or constructive. The Commission on Medical Education, whose problems have been more on a line with the investigation of this committee, had nothing to offer except perusal of their preliminary report, which is very thorough. Some of the statements in this report are taken from the report of this Commission.

RECOMMENDATIONS AND CONCLUSIONS

Further contact with the officials of Dartmouth Medical School and the Trustees of the College, and a suggestion from the New Hampshire Medical Society that they as a body stand ready to support any constructive policy decided upon by the College Trustees toward the reestablishment of a four-year medical course, whenever in their judgment such action seems wise.

The State Board of Registration to notify yearly each eastern medical school, of all communities really desiring a resident physician.

Rural inhabitants must realize their own responsibilities toward the physician. The physician in a small community should be more loyally patronized by his neighbors, for he is probably as competent as the physician of the neighboring town. After the physician has rendered service he should be recompensed adequately and in accordance with present-day standards of remuneration and not according to standards of fees of a quarter of a century ago, as is so often the case today. The fees charged by "old Dr. Smith or Dr. Jones," who began practice in the last century, cannot be proffered to the young, well-educated and ambitious practitioner, as an inducement to enter country practice.

We believe that more consideration should be shown rural physicians by the physicians in neighboring cities. We believe it is detrimental to good feeling and injures the local physician in the eyes of his neighbors, when physicians from cities make house calls in smaller towns already provided with adequate medical service. Where towns have adequate medical service, city physicians will promote better ethical relations and better support from rural physicians by limiting their services in such towns to consultations only.

Physicians in rural communities are urged to encourage ambitious young men in their localities to study medicine, and to encourage them to return to their own localities to practice.

Communities desiring resident physicians should

be prepared to guarantee adequate compensation and moral support. We recommend to town authorities that requests for resident physicians be conducted through the State Board of Registration.

The importance of this subject in its two aspects is so great that further progressive study will be necessary. The project of reopening the four-year medical school involves so many complicating factors that it will require thorough and exhaustive study before anything constructive can be brought forth. The final decision rests with the College Trustees.

We recommend this report be given publicity throughout the State, by means of reprints and newspapers.

GEORGE C. WILKINS, *Chairman*,
LOUIS W. FLANDERS,
FRED E. CLOW,
H. O. SMITH,
CHARLES DUNCAN.

Referred to Committee on Officers' Reports.

Adjourned until 9 o'clock Wednesday, June 22.

To be continued in later issue

NEW HAMPSHIRE MEDICAL SOCIETY NEWS ITEM

THE HILLSBOROUGH COUNTY MEDICAL SOCIETY met at 10 A. M. at the Manchester Country Club, Manchester, N. H., Tuesday, October 4th, 1927. The Women's Auxiliary to the Hillsborough County Medical Society met at the same time and place. Separate programs were arranged. Lunch was served at 12:30 P. M.

NO GRAFT IN THE NEW YORK CITY HEALTH BOARD

DR. L. I. HARRIS, Health Commissioner has issued a challenge to any person to find graft in his department.

This challenge is in answer to a charge by David Hirshfield that everybody familiar with the New York City government knows that inspectors in the Health Department and other departments have accepted money since the time that there was a city government in the City of New York.

TRAVEL STUDY CLUB OF AMERICAN PHYSICIANS

THE Travel Study Club of American Physicians announces a Study Tour for 1928 to Spain, the Riviera, Northern Italy, Budapest, Vienna, Munich and Bavarian Health Resorts, Berlin and Hamburg, visiting clinics and medical institutions.

The Tour starts June 30th, 1928, and will take two months. Dr. Fred H. Albee of New York is President, and Dr. Richard Kovacs of 223 East 68th Street, New York, to whom inquiries for further details may be addressed, is Secretary.

THE BOSTON Medical and Surgical Journal

Established in 1838

Published by The Massachusetts Medical Society under the jurisdiction of the following-named committee:

For three years	JOHN W. BARTOL, M.D. HORACE D. ARNOLD, M.D. CHANNING F. FORTHINGHAM, M.D.
For two years	HOMER GAGE, M.D., <i>Chairman</i> EDWARD C. STREETER, M.D. EDWARD W. TAYLOR, M.D.
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SUBSCRIPTION TERMS: \$5.00 per year in advance, postage paid for the United States, \$7.50 per year for all foreign countries belonging to the Postal Union.

Material for early publication should be received not later than noon on Saturday. Orders for reprints must be sent to the Journal office, 126 Massachusetts Ave.

The Journal does not hold itself responsible for statements made by any contributor.

Communications should be addressed to The Boston Medical and Surgical Journal, 126 Massachusetts Ave., Boston, Mass.

AN ASSOCIATION WITH THE NEW HAMPSHIRE STATE MEDICAL SOCIETY

In this issue we begin the publication of the transactions of the New Hampshire State Medical Society. This material will appear in installments and a copy of the JOURNAL containing these records will be sent to every member of the New Hampshire Society.

Those New Hampshire physicians who would like to have the JOURNAL every week throughout the year may receive it on paying three dollars, over and above that paid by the New Hampshire State Medical Society, provided that seventy-five or more take advantage of this offer. This places our New Hampshire subscribers on almost an equal footing with the Fellows of the Massachusetts Medical Society.

We especially request news items relating to medical affairs in New Hampshire and welcome contributions of interesting matter.

The JOURNAL Staff will try to make this publication useful to the profession in New Hampshire.

THE MEDICAL PROFESSION AND THE NEWSPAPERS

FROM time to time we see in the newspapers, either in Associated Press or United Press despatches or as local items, some story with regard to medicine which has perhaps no bearing on the conditions, is perhaps inaccurate, or presented as new when it is a well known method. We read it, shrug our shoulders, and perhaps wonder how anyone could be so foolish as to run it.

However, there are certain things we must keep in mind. Especially important is the fact that newspapers are after news. The more interesting that news is, the better it is. Medical discoveries reach home to many people, consequently from the point of view of the newspaper man they make valuable news. However, the medical profession does not meet the newspaper man halfway. We go to the editor and to the reporter to obtain publicity about our hospitals, our clinics, the meetings of our local or State societies. When they want information from us, however, we are loath to give it to them. We have found that the average editor is only too glad to coöperate with us in reporting medical news occasionally. The chief complaint of the newspaper man is that he can not get adequate and authoritative statements on medical subjects due to the prevalence of the age-long inhibition imposed on physicians by ethical considerations in avoiding publicity. More and more, however, the medical societies are coming to realize the value of publicity and the need for combatting the cults through the public press. A number of medical societies have established committees for this purpose which have functioned quite successfully. One very simple thing to do would be to give the straight facts to the newspapers when they ask for them, providing it may be done without advertising or undue publicity.

What can be done with the coöperation of the newspapers is well instanced in the handling of the discovery of insulin. When insulin was first used newspapers got an inkling of it. The editors were told, however, that the use of insulin was still in its experimental stages and that there was not an adequate supply to treat all those who would desire it once it became known to the general public. Consequently, through the coöperation of the press, mention of insulin was kept out of the newspapers for some months until its value was fully established and until an adequate supply was assured, and then the publicity was handled in a dignified, careful way. It would be a very helpful thing if there were some group of men appointed by either local medical societies or State societies where newspaper men could obtain definite statements with regard to news items which have come into the paper, and also to give out to the papers such items as they feel would be of value to the community.

The writer knows, from personal experience,

that several of the Boston newspapers are willing to entirely kill, or materially modify items which have been sent to them either from local correspondents of the Associated or United Press, and have willingly coöperated in giving the type of publicity desired by various established medical organizations. In fact, in handling the newspaper publicity for the meeting of the American College of Surgeons here, several years ago, we found that it was possible to run a large amount of material which was desired to reach the public which, without the coöperation of the newspapers could have been handled only as paid advertisements, such as information relative to the requirements and standards of hospitals, and other information with which the public should be familiar and yet which had no news value in itself.

There has been a great deal of discussion as to the type of publicity the medical profession should seek, and indeed, whether it should seek publicity at all, but if we do desire it there will certainly be little difficulty in coöperating with the newspaper men.

ARE PHYSICIANS AS A CLASS INTERESTED IN PSYCHIATRY?

THE growing interest in mental phenomena by a considerable number of physicians is testimony to the soundness of the claim made by psychiatrists that the successful practitioners of the future will of necessity have to be familiar with the fundamental impulses and reactions governing human behavior.

It is true that some persons have intuitions which, aided by careful observation and reasoning, enable them to understand the emotions and the responses to influences which lead up to exhibitions of abnormal individual conduct. Such practitioners are astute and influential in dealing with the problems of routine medicine but may not accomplish as much in controlling the behavior of a delinquent as would be likely under the direction of the trained psychiatrist. But in many instances, it would enable the practitioner to appreciate the necessity for more expert study of a given case and thus lead to the employment of appropriate means to direct the variant into normal habits of behavior within his capacity. The Commonwealth of Massachusetts has recognized the wisdom of requiring a demonstration of some knowledge of psychiatry by those who seek to qualify as practitioners of medicine by the adoption of the act which requires the Board of Registration to incorporate questions in this subject in the examination of candidates. It would be of advantage to the Commonwealth if all practitioners could be led to study the pathology and diagnosis of deviations from normal mental conditions.

In common with other organizations interested in preventive medicine, the Massachusetts Department of Mental Diseases is publishing

material from time to time setting forth and elucidating facts which must be recognized if the medical profession is to meet the expectations of those conversant with the problems of psychiatry. This responsibility consists both in individual study of patients under observation and still more the education of those within the range of the doctor's influence. As Mr. Henry Shattuck has aptly said, doctors must take the public into their confidence if success is to be attained in public health programs.

Fortunately opportunities for study are regularly placed at the disposal of the doctors through the bulletins issued by the Massachusetts Department of Mental Diseases. A perusal of these bulletins is interesting to all who wish to learn about the problems of this department. The latest bulletin, Volume X Nos. 3 and 4 has been distributed. The following subjects are discussed:

"The Importance of Early Years," by Douglas A. Thom, M.D.

"Delinquency," by Karl M. Bowman, M.D.

"Why an Interest in Mental Hygiene," by C. A. Bonner, M.D.

"Environmental Handicaps of 400 Habit Clinic Children," by Bertha C. Reynolds.

"General Problems U. S. Veterans' Bureau," by Douglas A. Thom, M.D.

"Personality Deviations and Their Relation to the Home," by Sybil Foster.

It should be kept in mind that Massachusetts is spending \$13,884,824.76 for public health. This vast sum is more than a fourth of the expenditure for all purposes by this State and of the sum noted above over ten millions of dollars are expended for the care of the mentally afflicted.

In all probability the medical profession is more familiar with other forms of public health work and it is becoming more important that doctors should study the problems of psychiatry and render all possible assistance in bringing to bear intelligent study of all who show indications of abnormal mental traits. It is reasonable to expect that doctors will not consign these bulletins to the wastebasket without first devoting time to a careful study of this valuable material.

DO UNIVERSITIES USE RATHER THAN FOSTER HEALTH?

DR. JAMES F. ROGERS, Chief of the Division of Physical Education and School Hygiene of the Bureau of Education, has issued a statement criticising the importance placed upon athletic supremacy in most of our universities and colleges. He contends that the proper function of educational institutions so far as health and physical development of the general student body is concerned lies in promoting the well being of all the students rather than encouraging the specialized types of athletes.

He believes that "after school memories are chiefly physical rather than mental athletics and that in the mind of the average alumnus sports occupy an exalted position so that it is difficult to say whether the schools manage the athletics or the athletics run the schools" and that inter-collegiate sports "make use of rather than cultivate health and physique."

While it is recognized that medical inspection and care of the health of the students is more general and better done than formerly it is probable that much more may be done to advantage in some educational institutions.

To bring about better results it may become the rule to so arrange physical activities that every student will have his bodily needs specified and proper exercises required under supervision.

It is undoubtedly true that some students are too little concerned about health and too much interested in mental exercises and when the report of Dr. Forsythe of the University of Michigan, and that of the Committee of fifty on college hygiene shall have been made public all institutions of learning will have information which will be helpful in formulating requirements with respect to athletic exercises.

It is generally conceded that a winning football team is a potent advertisement and tends to draw students from certain types of prospective applicants for admission to college. This appeal to young people has value, for some will become interested in college life and thereby secure more of an education than would otherwise be the case. Even the winning team has influence for good as an example of physical prowess and mental alertness which might stimulate an indolent youth. Hero worship has its value but in estimating all phases of athletics the needs of the general student body should always be kept in mind.

Arguments with respect to health must fairly consider a multitude of phases of bodily and mental growth and the great interest now centered on education will lead to appreciation of the problems at hand and the employment of methods for producing the best types of future citizens.

After all is said we hope that the grouchy alumnus will not postpone contributions to university needs until a winning team can be created. Sports must be a means to an end much more important than athletic supremacy.

THIS WEEK'S ISSUE

CONTAINS articles by the following named authors:

FULLER, ALVAN T. Governor of the Commonwealth of Massachusetts. His subject is "Opening Address." Page 551. Address: State House, Boston.

BIRNIE, JOHN M. A.B., M.D. Harvard 1906.

F.A.C.S., President of the Massachusetts Medical Society, Secretary of the New England Surgical Society. His subject is: "Cancer and the Medical Profession." Page 552. Address: 14 Chestnut Street, Springfield.

KELSO, ROBERT W. A.B., LL.B., Executive Secretary of the Boston Council of Social Agencies. His subject is: "Cancer and the Public." Page 553. Address: 46 Cornhill, Boston, Mass.

SOPER, GEORGE A. B.S., M.A., Ph.D., Managing Director of the American Society for the Control of Cancer. His subject is: "National Aspects of the Cancer Problem." Page 554. Address: 25 W. 43d St., New York, N. Y.

HOPKINS, WILLIAM T. M.D., Boston University School of Medicine 1890, Chairman of Cancer Committee, Lynn Medical Fraternity. His subject is: "Cancer Clinics." Page 556. Address: 7 Atlantic St., Lynn.

NICHOLS, JOHN H. M.D. Harvard Medical School 1892, Superintendent and Resident Physician of the State Infirmary, Tewksbury since 1897. His subject is: "Cancer and Public Dependents." Page 557. Address: Tewksbury, Mass.

GREENOUGH, ROBERT B. M.D. Harvard Medical School 1896, F.A.C.S., Assistant Professor of Surgery at Harvard Medical School, Visiting Surgeon to Massachusetts General Hospital, Surgeon-in-charge of Collis P. Huntington Memorial Hospital. His subject is: "The Service of the Pondville Hospital at Norfolk." Page 560. Address: 8 Marlboro St., Boston.

MISCELLANY

THE EDWARD K. DUNHAM LECTURESHIP

In 1923 there was founded in memory of Doctor Edward K. Dunham (M.D. Harvard 1886), the Edward K. Dunham Lectureship for the Promotion of the Medical Sciences. Among the useful purposes for which the Foundation was established was that of binding closer "the bonds of fellowship and understanding between students and investigators in this and foreign countries." The lecturers are chosen from "eminent investigators and teachers in one of the branches of the Medical Sciences, or of the basic Sciences which contribute towards the advance of Medical Science in the broadest sense." The lectures, which are given annually, are "free and open to the faculty and students of the Harvard Medical School and College, and all other interested professional persons who may profit by them."

Three lectures will be delivered this fall by Sir Charles Scott Sherrington under this foun-

dition: These lectures are to be given at the Harvard Medical School in the Amphitheatre of Building C at 5 P. M. The schedule follows:

Monday, October 10, "Observations on Stretch Reflexes."

Thursday, October 13, "Modes of Interaction between Reflexes."

Monday, October 17, "Some Factors of Coördination in Muscular Acts."

Please note that the date of the first lecture is October 10 and not October 19 as incorrectly stated in our JOURNAL of September 22 (page 498).

ARE THE UPPER CLASSES DYING OUT?

DR. ELLSWORTH HUNTINGTON, research Associate at Yale University has stated in the October issue of *Yale Review* that he regards the lessened birth rate among the higher classes of people as an indication that this may mean a gradual extinction of certain intellectual types.

SHELLFISH CONTROL REGULATIONS ARE ADOPTED IN TEXAS

SHELLFISH control regulations designed to meet the minimum requirements laid down by the United States Public Health Service have been announced by Dr. J. C. Anderson, State health officer. A copy of these regulations, together with a letter calling attention to sanitary standards necessary in the taking and handling of shellfish, have been sent to all engaged in the oyster industry.

PACKING COMPANIES NOTIFIED

"Oyster packing companies have also been notified," Dr. Anderson stated, "that companies failing to meet the minimum sanitary standards specified, will not be permitted to ship oysters out of the State. A survey, conducted by the staff of the hygienic laboratory of the State Department of Health of oyster producing areas, has just been completed, and a survey of shucking and packing plants along the coast has been started. E. H. Gage, associate sanitary engineer of the United States Public Health Service, in charge of shellfish sanitation for this district, and Chester Cohen, district sanitary engineer, are conducting the latter survey.

REGULATIONS CITED

"Some of the regulations governing the taking and handling of shellfish are: No shellfish shall be taken from any waters except from such growing areas as approved by the State Department of Health; shellfish shall not be floated, stored or cleansed in water other than that of standard purity; all boats used in the taking and handling of shellfish shall be kept in a good sanitary condition; shellfish held in stor-

age must be kept so as not to be contaminated; accurate daily records must be kept by all wholesale companies; and definite regulations concerning construction, lighting, ventilation and equipment of shucking and packing plants."—*U. S. Daily*.

CHANGES IN REGULATIONS COVERING LIQUOR PERMITS AND PRESCRIPTIONS

THESE changes have been published in the *United States Daily* as follows:

1. All permits outstanding on October 1, 1927, and all new permits issued on and after that date hereafter will be required to be renewed annually. This change affects a large class of permits which heretofore have been treated as continuing in force until surrendered or revoked for cause.

2. Requirement is made that all permittees shall provide a safe and secure place of storage located on permit premises, to be inspected and approved by the administrator, and of sufficient capacity to hold the maximum quantity of intoxicating liquor authorized to be possessed at any one time. Under previous regulations only certain classes of permittees were required to furnish such storage.

3. The method heretofore in use of fixing the allowances of liquor withdrawals for nonbeverage purposes on a quarterly basis has been changed to an annual basis with a restriction that not more than 50 per cent of the annual allowance may be possessed by a permittee at any one time.

4. Further restrictions are made on prescriptions of liquor for medicinal purposes by a new provision that a prescription for liquor must be filled within three days after it is issued unless the physician extends the time for not exceeding an additional three days, and a new requirement that compounded prescriptions in which potable distilled spirits are used may not be written or filled for a gross quantity in excess of six fluid ounces.

5. Provisions are made for new forms of applications for permit and permits containing stipulations for inspection of permit premises and records, designation and approval of managers of permit business, termination of permit in the event of change of ownership or management, description of storage place, and revocation of permit for violation of prohibition laws or regulations by the permittee or other persons employed by him in the exercise of the permit privileges.

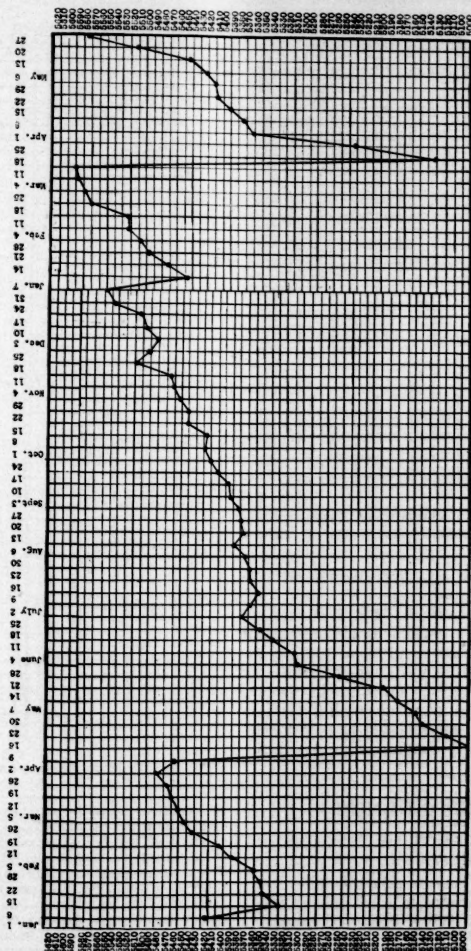
If these changes mean, as the text seems to show, that physicians shall have to have a place of storage other than ordinary household or office equipment, another annoying requirement is thereby imposed.

SOME FACTS BEARING ON THE CIRCULATION OF THE JOURNAL

Most readers of this JOURNAL know that it is owned and maintained by the Massachusetts Medical Society.

venient to do so. The Society has directed the managers of the JOURNAL to discontinue sending the JOURNAL to those members who are in arrears March first and as soon as the returns from the district treasurers are recorded the names of members who have not paid are taken

GRAPH SHOWING CIRCULATION OF THE BOSTON MEDICAL AND SURGICAL JOURNAL FROM JANUARY 1, 1925 TO JUNE 1, 1926



GRAPH SHOWING DROP IN CIRCULATION OF THE BOSTON MEDICAL AND SURGICAL JOURNAL AT THE TIMES WHEN DELINQUENTS ARE TAKEN FROM THE MAILING LIST

A large proportion of the members of the Society know that payment of the annual dues includes a subscription for the JOURNAL for the year which the dues cover.

About four hundred members of the Society or about ten per cent. of the roster either forget to pay dues at the proper time or find it incon-

venient to do so. This makes an irregular record of circulation figures which represents to some extent the financial habits or conditions of this portion of our members.

It is interesting to note according to the line cuts below that in April, 1925, the unpaid dues reduced the mailing list by 480, in 1926 the re-

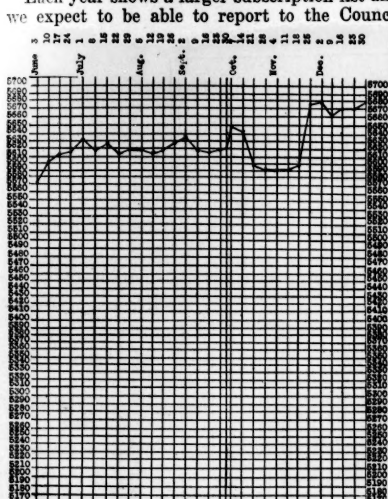
duction amounted to 445, and in 1927 it was 495.

With the omission of the JOURNAL membership dues are gradually paid so that the peak is reached the latter part of the year.

Each year shows a larger subscription list and we expect to be able to report to the Council

in diminishing the appropriation for the JOURNAL can help by demonstrating to advertisers that it pays to use our pages.

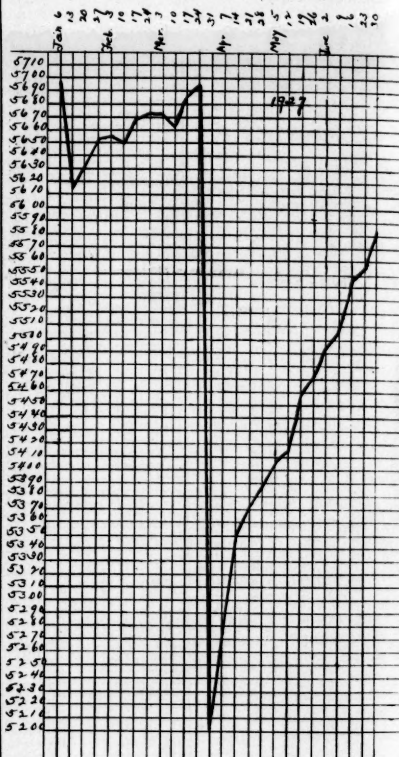
The prompt payment of dues and dealing with our advertisers will help the JOURNAL.



GRAPH SHOWING CIRCULATION OF THE BOSTON MEDICAL AND SURGICAL JOURNAL FROM JUNE 1, 1926, TO DECEMBER 31, 1926

Meeting in February a larger average circulation than ever before attained.

We have become convinced that our members do not pay as much attention to advertisements as would be advantageous to them and to the JOURNAL. There have been opportunities for economies in purchasing supplies in several ways as set forth in our advertising sections which have not been appreciated to any considerable extent. Those readers who are inter-



CIRCULATION FROM JANUARY 6, 1927, TO JUNE 30, 1927

CORRESPONDENCE

FURTHER DISCUSSION OF ECONOMIC CONDITIONS

Editor, Boston Medical and Surgical Journal:

Since my letter published in your issue of May 5 I have received many replies from very well-known physicians in Boston and vicinity. Some of the writers disagree with my statements, on the other hand most of them congratulate me for my sentiments as expressed in the JOURNAL. I have answered only one of the many replies I have received.

May I inform the rest of the worthy physicians that there is a medical journal in the State of Massachusetts called the BOSTON MEDICAL AND SURGICAL JOURNAL? Are you worthy gentlemen of the medical profession afraid to express your opinions in your

own medical journal that they may be read by your own fellow practitioners?

Many of my fellow physicians ask me whether I believe that physicians should unionize. My answer is a counter-question. Are they not unionized now? What is a union but an organization to work for the interest of its members? I cannot see why the physician should look for any other organization if the county, state or national medical association would fight for the physicians' interest.

In the state of Missouri the county medical society has just passed a rule that every patient at the free clinics must bring a statement from a reputable citizen and from his family physician that he or she cannot afford to pay a physician's fee.

It seems to me that the entire difficulty lies in the fact that physicians are, as a body, disorganized, disunited and prejudiced against each other.

Competition is now so keen that, although at one time it may have been very valuable in that it furnished the incentive for the doctor to further educate himself, it is not serving its purpose now. It may have been a blessing. It is now a curse. The only remedy is union. The physician should have high ideals and much knowledge. The antagonism that now exists is *throat cutting*. Where there is union there is strength.

The doctor's only assets are his knowledge and his skill. Why not unite and determine a fee so that those who can pay will be unable to secure free treatment? Those who continually preach morality and ethics are generally members or staff members of some hospital. By giving aid to the wealthy at the free hospitals they are cutting the throats of their fellow practitioners.

Only recently a Chelsea bank trustee presented himself at the Massachusetts General Hospital for free surgical aid. Doubtless it pays those ethical gentlemen to admit bankers to the clinics occasionally. It is one way of securing wealthy patients for their own private practice. The majority of physicians not associated with the clinics have reason to despise these so-called charity clinics which are depriving them of their livelihood under the cloak of charity. But they offer another excuse besides that of charity. These hospital doctors claim that they need all available material for medical students. This statement is not well-founded. There are many people who really cannot afford to pay a physician's fee and who deserve free treatment. There are many criminals in the prisons. Use them as material for the medical students. There are many homeless cats and dogs. If necessary, use them for the study of surgery.

I am certain that thousands of medical men share my opinion. It is time for the medical men to assert themselves. The public should abandon the idea that the doctor is public property and that he should be content with remuneration in the hereafter.

It is important to read a paper on some new treatment of cancer and tuberculosis, but it is also important to know how to meet the landlord on the first of each month professionally, ethically, and legally.

The medical society members who are associated with a hospital can help to bring it about that none who can afford to pay a physician's fee should at any time be treated at a free dispensary or clinic.

If Mr. John Doe knew that in case he should fail to pay his doctor's bill his name would be blacklisted by the county medical society, he would be forced to pay.

I ask you, honorable gentlemen, what there is wrong or unethical about this. In one particular case I delivered the first baby in a family that could well afford to pay one doctor's or even two doctors' fees. The second baby was delivered by the Boston Lying-In Hospital. I wrote to that hospital before the delivery. Of course they promised to investigate but my word was not good enough. They delivered the case. The doctors on the staff of that hospital could have refused to serve that or any other hospital that tried so hard to take away the bread and butter of some honest physician. The lay trustees of such hospitals would sit up and take notice.

I hope and pray that improvement of the economic condition will come directly from the medical organization. If it does not the rank and file of physicians will sooner or later be forced to form some other organization, or call it union if you please, which will fight the battle of the physician honestly and sincerely.

For the sake of our medical profession, I am

Very truly,

WILLIAM FRANKMAN, M.D.

1325 Commonwealth Avenue, Boston.

September 15, 1927.

SUGGESTED INVESTIGATION OF INFLUENZA

Editor, Boston Medical and Surgical Journal:

In the issue of the JOURNAL for August 26, 1926, we published an article on "Influenza in Massachusetts" in which we made the conclusion "that the respiratory group, including influenza, may be unduly prevalent in Massachusetts during the winter 1926-27, as in 1916 or in 1921 and 1922, possibly as in 1899 or 1900, but there seems to be no reason to expect any great calamity such as that of 1918 or even that of 1891-93." This prediction was based on the similarity of the graphs following the epidemics of 1892 and 1920 and on a study of peaks since 1843. Table 2 indicated that the probability of a high peak following a spring peak was .7. The expected peak in the influenza mortality did not occur, although from unofficial reports and observations there was apparently a large number of light cases of influenza or grippal colds in Massachusetts. In England and Continental Europe there was a large number of cases of influenza of a virulent type. In spite of the close communication between the continents this virulent European type of influenza did not gain a foothold in Massachusetts. In view of the pandemic character of influenza the reason for its non-appearance in epidemic form in this country should be investigated. A study of localized occurrences of this disease in which a pandemic did not occur might give valuable information on the epidemiology of influenza.

HERBERT L. LOMBARD, M.D.,
CARL R. DOERING, M.D.

NOTICES

THE MIDDLESEX SOUTH DISTRICT MEDICAL SOCIETY will hold its Semi-annual Meeting on Tuesday, October 11, at the Wayside Inn, Sudbury, Mass. Dr. Allan W. Rowe of Boston will read a paper on "Diseases of the Endocrine Glands."

Business meeting at 11:30 A. M.

Dinner at 12.

Dr. Rowe's paper at 1 P. M.

DR. STEPHEN M. BIDDLE, *Secretary*.

THE STATE HOSPITAL FOR CANCER AT PONDVILLE

September 27, 1927.

To the Physicians of Massachusetts:

Pondville Hospital is the name of the State hospital for cancer, located in the township of Norfolk on the Boston-Providence Turnpike between Walpole and Wrentham. The hospital is now equipped to give full operative, X-ray, and radium service. While all types of cancer cases will be admitted, it is desirable, owing to the size of the hospital and the heavy cost at which it is being operated, that a large per cent of patients be of the type that can be benefited by our resources. The cases needing only custodial care will be admitted, only, if adequate care cannot be obtained elsewhere.

The hospital maintains an out-patient clinic which admits patients on Thursdays, 1-2 P. M. Here diagnosis and treatment will be available for all out-patients. Diagnosis is free, and a charge of \$1.50 per day is made for treatment.

The hospital is prepared to furnish adequate treatment to all types of cancer patients. The equipment includes radium and high-voltage X-ray.

Under authority of Chapter 236 of the Acts of 1927, the hospital charge to cities and towns for patients sent to the Pondville Hospital is \$2.50 per day, and the charge for patients paying their own fees is \$1.50 per day. These rates cover all expenses, including use of the operating room, radium, X-ray, etc., although the cost to the State is much higher. Under the statutes no person shall be deemed a pauper because of his inability to pay for his support in the Pondville Hospital.

The application blanks for admission to the hospital must be filled out by a registered physician. These may be obtained at the hospital, at 546 State House, Boston, from the local public welfare departments, or local boards of health.

The hospital can be reached by the New England Transportation Company busses; leaving Park Square, Boston, on the hour. Fare from Boston is ninety cents. The N. Y., N. H. and H. Railroad runs two trains daily from the South Station, Boston, in the afternoon. The fare is eighty-six cents. There are no return trains in the afternoon. The railroad station for visitors is Pondville, and for patients, Walpole. Patients will be met at the Walpole Station if the hospital is notified a day in advance. Automobiles take State Highway from Boston to Providence, U. S. Route No. 1.

The physicians of the State are invited to visit the hospital and to make use of the facilities offered.

Very truly yours,

GEORGE H. BIGELOW, M.D.,
Commissioner of Public Health.

REPORTS AND NOTICES OF MEETINGS

WINTER TRAINING COURSE FOR MEDICAL DEPARTMENT OFFICERS

The Winter Training course for Medical Department officers of Boston and vicinity for 1927-28 will open on October 12th, 1927, at 8:00 P. M., with a dinner at the University Club, 40 Trinity Place, Boston, Mass.

The opening meeting of 1926 was such a success that that committee has decided to start this winter's schedule in the same manner.

We will assemble in the Lounge on the 2nd floor of the Club at 7:45 P. M., and proceed to the banquet room.

The subscription price will be \$1.50 per plate.

The wearing of the uniform at this and other meetings is optional.

Officers attending these meetings will be given credit for participation in Military Activities.

There is ample parking space in the rear of the Club for your auto.

The committee of arrangements for this and the monthly meeting of 1927-28 in our Medical Winter Training Course are anxious to make this year a Banner year for attendance, and have adopted the slogan, "I will come and bring a friend to each meeting."

The Commanding General, First Coast Artillery District, Brig. Gen. William P. Jackson, will be present. Col. David D. Scannell, Medical Reserve, will act as Chairman of the meeting.

WM. LYSTER, Colonel, M.C.,
Corps Area Surgeon.

ANNUAL MEETING OF THE NEW ENGLAND SURGICAL SOCIETY

The annual meeting of the New England Surgical Society was held in Manchester, N. H., Friday and Saturday, September 30 and October 1, 1927. A dry and operative clinic was held at the Elliot Hospital during the forenoon of the first day. This was presented by the New Hampshire members of the Society assisted by Dr. Elmer J. Brown, Dr. A. S. Merrill and Dr. Ezra Jones of the hospital staff. A very interesting and instructive program was carried out on schedule time and received many favorable comments. A luncheon at the hospital followed. In the afternoon a literary program at the Carpenter Hotel was presented. The annual banquet took place at the Manchester Country Club the evening of the first day, at which Hon. Geo. H. Moses, senior U. S. Senator of New Hampshire was the speaker. Saturday forenoon and afternoon were devoted to the continuation of the literary program and was held at the Carpenter Hotel. Lunch was served at the hotel during the noon hour. The entire meeting was a decided success. Much credit is due Dr. George C. Wilkins, chairman of the committee of arrangements. The officers of this Society consist of:

President: D. F. Jones, M.D., Boston, Mass.

Vice-President: W. W. Townsend, M.D., Burlington, Vt.

Secretary Pro-Tem.: J. M. Birnie, M.D., Springfield, Mass.

Treasurer: P. P. Johnson, M.D., Beverly, Mass.

Recorder: W. G. Phippen, M.D., Salem, Mass.

Executive Committee: Officers of the society, D. Cheever, M.D.; J. B. Woodman, M.D.; P. E. Truesdale, M.D.; L. Allen, M.D.; W. H. Bradford, M.D.

Committee of arrangements: G. C. Wilkins, M.D., Chairman.

PROGRAM OF THE NEW ENGLAND ASSOCIATION
FOR PHYSICAL THERAPEUTICS, INC.

SECOND ANNUAL MEETING, OCTOBER 18, 19 AND 20,
STATLER HOTEL, BOSTON, MASS.

ALL LEGALLY REGISTERED PHYSICIANS ARE WELCOME

OFFICERS

President—Elmer F. Otis, M.S., M.D., Melrose, Mass.

Vice-Presidents—Claude L. Payzant, M.D., Medford, Mass.; Elisha Sears Lewis, M.D., Worcester, Mass.

Secretary—Whitman King Coffin, M.D., 366 Commonwealth Avenue, Boston, Mass.

Treasurer—M. A. Cohen, M.D., Boston, Mass.

Executive Council—Solon Abbott, M.D., Franklin, Mass.; Samuel J. Harris, M.D., Boston, Mass.; George J. Ott, M.D., Boston, Mass.; George E. Percy, M.D., Salem, Mass.; Arthur H. Ring, M.D., Arlington, Mass.; John F. Valentine, M.D., Danvers, Mass.

SPECIAL NOTICE

A banquet will be held in the Statler Hotel Wednesday evening, 8 P. M.

Guest of Honor—Rear Admiral Charles F. Stokes, M.D.

Honored Guests—William Benham Snow, M.D., Mary L. H. Arnold Snow, M.D.

Toastmaster—George J. Ott, M.D.

TUESDAY MORNING SESSION, OCTOBER 18, 9 A. M.

1. *President's Address.* Elmer F. Otis, M.D., Melrose.

2. *Physical Therapy in Neuropsychiatry.* Arthur H. Ring, M.D., Arlington. Mental disturbances broadly divided into two types. Type benefited by Physical Therapy. Importance of psychopathic predisposition, temperament and personality. Organic disturbances and their psychic correlates. Modalities: General effects on nervous system. Specific effects in arteriosclerosis, nephritis, chronic enteritis, anaemia, depression, mania, asthenic states, etc. Physical therapy a valuable adjunct.

3. *Heliotherapy.* W. H. Watters, M.D., Boston. Treatment of disease by sunlight. Advantages and disadvantages of that method as compared to artificial light.

4. *The Therapeutics and Dosage of the X-Ray.* William Benham Snow, M.D., New York City (Honorary Member). A brief history and final conclusions as to the actions and dosage, with report of cases illustrating the point of view.

5. *Physical Therapy for the General Practitioner.* Solon Abbott, M.D., Franklin.

TUESDAY AFTERNOON SESSION, OCTOBER 18, 2 P. M.

6. *Symposium on Treatment of Chronic Biliary Tract Disease.*

6. 1. *Medical Aspects.* Anthony Bassler, M.D., New York City.

7. 2. *Physical Therapy Aspects.* Claude L. Payzant, M.D., Medford.

8. 3. *Surgical Aspects.* Howard M. Clute, M.D., Boston.

9. *The Role of Static Electricity in Medicine.* Mary L. H. Arnold Snow, M.D., New York City (Honorary Member). Physiological action. Methods of application. Indications for the orthopedist, surgeon, pediatrist, gynecologist, general practitioner. Case reports.

10. *Physical Therapy in the Treatment of Gonorrheal Urethritis in the Male.* William Bierman, M.D., New York City. The relationship between physical therapy and other methods employed in the treatment of gonorrheal urethritis. The methods of applying diathermy. Results of the application of diathermy.

ROUND TABLE DINNER

Tuesday, 6 P. M., at the Boston Square and Compass Club, 448 Beacon Street, Boston.

TUESDAY EVENING SESSION, OCTOBER 18, 8 P. M.

11. *Visual Teaching in Electrotherapy* (With demonstrations and lantern slides). Richard Kovacs, M.D., New York City. Visualization of physics and mode of action of various currents essential for rational therapeutic application. Charts. Readily performed experiments and demonstrations with galvanic, faradic, sinusoidal, diathermy and static currents.

12. *The Effective Ultra Violet.* William T. Anderson, Jr., Ph.D., Newark, N. J. The spectral range of ultra violet 1/15 of our known spectrum; not all therapeutically effective. Ultra violet of sunlight through window glass little effective. A careful determination of the effective ranges requires a physicist experienced in ultra violet light and light measurements. A cooperative experiment has demonstrated much greater penetration of the shorter ultra violet through living tissue than was formerly supposed. Wave length, intensity and duration of application all important.

13. *Clinical Demonstration of Physical Measures and Exercises in Ophthalmic Practice.* Dr. Samuel J. Harris, Boston. Galvanism, sinusoidal, diathermy, pneumo-massage, ultra violet, radiant light and heat, X-Rays, relaxation and exercises.

WEDNESDAY MORNING SESSION, OCTOBER 19, 9 A. M.

14. *The Tonsil Problem.* Charles F. Stokes, M.D., New York City. Brief discussion of the methods employed in dealing with diseased tonsils, including tonsilectomy, desiccation, electrocoagulation and the use of the electrotome; immediate and remote results; types of anaesthesia; conclusions.

15. *Diseased Tonsils and Their Treatment by Electrocoagulation, Radium and Surgery.* Jeremiah J. Corbett, M.D., Boston. Comparison of the efficiency of various methods. Choice, selection of cases, method of treatment. Results: immediate, post-operative and end results.

16. *Management and Treatment of Ear, Nose and Throat Conditions by Physical Measures.* Charles R. Brooke, M.D., New York City. Combination of modalities employed, technique of application, citation of some practical points observed in the treatment of a large number of cases. Cooperation and team work between the internist and the otolaryngologist.

17. *Detoxication by Treatment of Chronic Focal Infection.* Philip H. Greeley, M.D., Portsmouth, N. H. Including diagnosis of symptoms and method of combating by removal, or palliation with some form of physical therapy.

18. *The Physical Treatment of Arthritis.* Curran Pope, M.D., Louisville, Ky.

WEDNESDAY AFTERNOON SESSION, OCTOBER 19, 2 P. M.

19. *Cancer Metastasis.* E. H. Trowbridge, M.D., Worcester. Probable causes, incidence in different organs involved. Operated on by endothermy, showing remarkable control of hemorrhage, absence of pain, rapid recovery and freedom from post operative shock. With slides.

20. *Extension of the Surgery of Neoplastic Diseases by Electrothermic Methods.* George Austin Wyeth, M.D., New York City. Scalpel not applicable to large percentage of cancer cases. Electrothermic methods offer an extension of surgery's usefulness. Excision by endotherm knife sterilizes and seals lymphatics as it cuts. Tends to protect from danger of metastasis and likelihood of recurrence, is cleanly, keeping field practically free from blood. Special technique.

21. *Surgical Diathermy.* John H. Cunningham, M.D., Boston.

22. *Excision of Prostatic Bar by the Cutting Current.* Clyde W. Collings, M.D., New York City. The cutting high frequency current is applied to the bladder neck through the pan-endoscope. Indications: 1, Fibrous contracture and bar; 2, Fibrous scar following prostatectomy; 3, Carcinomatous bar, from prostate carcinoma. Not used on adenomatous hypertrophy of the prostate. Patient usually gets immediate relief, and can be discharged from the hospital in forty-eight hours.

23. *Rectal Diseases Treated by Physical Therapy.* George J. Ott, M.D., Boston. Surgical diathermy and desiccation the treatment of choice in hemorrhoids, internal and external, polypus, fissure, ulcer, early cancer, fistula and prolapsus. Indications for other modalities.

WEDNESDAY EVENING SESSION, OCTOBER 19, 8 P. M.

BANQUET

Guest of Honor—Rear Admiral Charles F. Stokes, M.D.

Honored Guests—William Benham Snow, M.D., Mary L. H. Arnold Snow, M.D.

Toastmaster—George J. Ott, M.D.

THURSDAY MORNING SESSION, OCTOBER 20, 9 A. M.

24. *Infectious Arthritis.* Herman G. Wahlig, M.D., Seacleft, L. I. Shoulder joint, acute osteomyelitis with abscess formation. Careful examination, blood chemistry, urinalysis and X-Ray. Pyorrhea shown as original cause. Treatment: diet, rest, hygiene, diathermy, Kromayer, static and sinusoidal. Extraction of teeth. Etiology—pyorrhea alveolaris.

25. *The Treatment of Cervix Uteri by Means of Physical Therapy, as a Prophylaxis of Cancer.* Arthur L. Brown, M.D., Winchester. Infections in vagina, traumatic lesions from labor, erosion of the cervix, result of persistent leucorrhoea, and cystic degeneration.

26. *Response of Fibroid Tumors of the Uterus to X-Ray Therapy. Report of Ten Cases.* Lucy Osborne Wight, M.D., New York City. A group of cases treated with low voltage X-Rays. The pathology and literature of fibroids, technic, number of treatments, etc. Details and results. One case coming to operation immediately after course of radiation showed gross changes in uterus and ovaries. Compare X-Ray versus radium in treatment of simple fibroids.

27. *The Hemorrhagic Uterus. Etiology, Pathology, Symptomatology and Progress.* DeWitt G. Wilcox, M.D., Boston. Types that call for surgical treatment, and those requiring only non-surgical, and physical therapy. Effect of approaching menopause upon the hemorrhagic uterus.

28. *Electro-physical Therapeutic Modalities on the Redundant Colon.* Joseph N. Chausse, M.D., President of the Canadian Electrotherapeutic Association, Montreal, P. Q. (Honorary Member). X-Ray findings, analysis of blood, etc., different modalities, Roentgenographs after treatment.

29. Title to be announced. Franz Nagelschmidt, M.D., Berlin, Germany (Honorary member).

THURSDAY AFTERNOON SESSION, OCTOBER 20, 2 P. M.

30. *Physical Therapy in Orthopedic Practice.* Howard Moore, M.D., Boston. Percentage of orthopedic cases treated by physical measures. Types of cases showing indications for, and responding to physical therapy.

31. *Physical Therapeutic Measures in Indolent Ulcer.* M. A. Cohen, M.D., Boston. Classification, etiology and pathology. Comparative methods of treatment. Physical therapy offers the best means for relief and symptomatic cure.

32. *The Reaction of the Body to the Short Cold Bath.* W. H. Riley, M.D., Battle Creek, Mich. Short cold bath, one-half to two minutes; reaction or effects on human body recorded before and after, i. e., physi-

ological changes in body as to function, muscular capacity, cardio vascular tonicity, tension and metabolism. Contraindications.

33. *A Rational Treatment of Peripheral Facial Paralysis.* Louis Feldman, M.D., Boston. Etiology, symptomatology, pathology, prognosis. Tests for degeneration. Physical measures the method of choice in true peripheral facial paralysis. Modalities employed. Successful treatment, with reduction of complications.

34. *Posture Film.* From United States Department of Labor, Children's Bureau, Washington, D. C.

REGISTRATION

All physicians attending the sessions are requested to register at the desk before entering.

OPENING HOURS

The opening hours are 9 A. M. and 2 P. M. and the sessions will start promptly on time. This is necessary on account of a full program.

EXHIBITS

An exhibit of apparatus and other adjuncts to the practice of medicine and surgery will be shown in the Exhibit Hall immediately adjoining the Meeting Room.

LADIES

An entertainment committee will be on hand to be of service to the ladies who come. Information as to theatres and other points of interest will be available.

THE BANQUET

The banquet which will be held Wednesday evening, 8 P. M., at the Hotel Statler, will afford a good opportunity for getting acquainted. The charge is \$3.50 per person, and all who attend the convention are invited to the banquet.

BOOK REVIEWS

The Anatomy of the Nervous System from the Standpoint of Development and Function, by STEPHEN WALTER RANSON, M.D., Ph.D., Professor of Neuroanatomy, Washington University Medical School, St. Louis, Mo. Third edition, revised. Octavo. 425 pages. 284 illustrations. Philadelphia and London: W. B. Saunders Company, 1927.

The third edition of this anatomy of the nervous system contains little new matters; two illustrations and a description of microglia and oligodendroglia, according to the researches of Rio Hortega, have been added. The book is not essentially changed in any way and is, therefore, open to the same criticisms expressed in a review of the first edition in 1920, some points of which might be reiterated.

Attempt has been made to correlate development and function with structure in accordance with the newer ideas of anatomy from the dynamic point of view. Because of this the book suffers, being limited in size, and much of importance in anatomy is excluded. For instance, there is no adequate description of the circulation of the central nervous system; one fails to find such an important structure as the vein of Galen in the index; no mention is made

of the possibility of non-medullated fibres either being found in or innervating the voluntary muscles. It is also difficult, apparently for an anatomist to think clinically, except with the aid of the roughest diagrams. The few "clinical illustrations" appended to the volume only serve to give the student a false idea of the complexities of neurology.

In spite of its faults, the book, to the reviewer, seems to have distinct merit. When used as a laboratory manual, it is so arranged that sections of either the shark's or sheep's brain can be substituted for the human brain and still be correlated with the text. The book, in its present form, is somewhat superior to the larger volume written on similar lines by Tilney and Riley. As a students' textbook, written by an active teacher of neuroanatomy, it can be recommended for school use. The clinician will find better descriptive anatomy in Quain Déjerine, or Gray and better neurology in Judson Herriek's "Introduction to Neurology."

JOSEPH, BARON LISTER; *Centenary Volume*, 1827-1927. Edited for the Lister Centenary Committee of the British Medical Association by A. LOGAN TURNER, PH.D., LL.D. Edin. Oliver and Boyd, Edinburgh and London, 1927.

Centenaries are valuable criteria of the greatness of men. If they are still remembered and revered an hundred years after their birth, their greatness was real and their works may with profit be recalled to a generation which is benefiting by them.

Lister, the Englishman turned Scot, found Surgery at an impasse, foiled in every attempt at advance by the spectre of sepsis. By the application of Pasteur's discoveries he became the founder of the modern scheme. Antisepsis has given way to asepsis, but every triumph of the surgery of today is founded on the principles outlined by Lister.

The centenary volume of Lister is not a biography of the man; it is a memorial to him, reverently created by those who still recognize him as the Chief. The contents include a biographical sketch; an analysis of the state of surgery preceding Lister; Lister as a Physiologist; selected writings: The Influence of Lister's Work on Surgery; a chapter of reminiscences; Letters of Lord Lister, and sketches of the careers of Lister's fellow-residents at Edinburgh.

Standard Methods of the Division of Laboratories and Research of the New York State Department of Health. AUGUSTUS B. WARDSWORTH, M.D. pp. 704. Williams & Wilkins Company, Baltimore, 1927.

Practically all those doing bacteriological and serological work are familiar with, or using materials produced by the Division of Labora-

tories and Research of the New York State Board of Health. Their methods are so well established and well tried that it is a distinct advantage to other laboratories to have the detailed procedures available to check their own methods against. Practically every portion of the laboratory methods in bacteriology and serology is given in detail, from the preparation of glass-ware and media to the Weil-Felix reaction and the preparation of pertussis vaccine. The book is of considerable interest to the physician if only to know how the materials on which he depends for diagnostic procedures and for treatment are produced.

A rather interesting section is that portion dealing with the methods used in the Research and Publications Departments, showing the plan of administration both in general and in detail. Any effort to systematize research is particularly interesting, especially if it seems in some degree feasible.

While the field of this volume is naturally somewhat limited, probably every large hospital laboratory would find it of considerable value as would all those interested in the production and the preparation of biological products.

Birth Injuries of the Central Nervous System.

By F. R. FORD, BRONSON and MARIAN C. PUTNAM, Harvard Medical School. Baltimore: Williams & Wilkins Company. 164 pages. Price, \$4.

This book consists of two parts, the first dealing, according to the title, with cerebral birth injuries and the second with spinal cord birth injuries. Of the two the second is far superior and alone justifies the publication of the book.

This latter is a well arranged and considered article dealing with those injuries of the spinal cord that have been sustained by the foetus during labor or delivery, their end results, pathology and symptomatology. Numerous case reports, photographs and diagrams, illustrative of the various points under consideration, are presented. A review of the apposite literature is added and the monograph concludes with a concise summary of the detailed material made under such headings as etiology, pathology, and clinical considerations, capped by a "conclusion" that welds all previous parts into a concrete whole. The authors, Crothers and Putnam, had a point that they wished to make, presented evidence supporting it, drew their conclusions, and, as a result, have contributed valuable matter, not only to the neurology of childhood, but also to the art and science of obstetrics.

The first section, on the other hand, written by Ford and dealing with cerebral birth injuries and their results, is as disappointing as the sec-

ond is satisfactory. It consists, mainly, of a "Literary Digest" review of the papers written on intracranial damage in the newborn with an occasional half-hearted attempt to make a point, usually with the aid of quotations from the more obsolete of the authors cited. An appendix lists certain case histories and presents charts purporting to demonstrate the relationship between cerebral damage at birth and its late effects as exemplified by hydrocephalus, epilepsy, and various types of paralyses seen in older children. As one reads this section the impression is inevitable that the author holds certain views which he has been unable to crystallize for lack of sufficient evidence and in consequence, has done the best he could with the aid of carefully chosen quotations from the literature. This monograph is a disappointment and can serve no useful purpose other than to provide future writers with a convenient index to the literature on this subject.

Pharmaceutical Botany. By HEBER W. YOUNG-KEN, A.M., M.S., Ph.M., Ph.D., Professor of Botany, Pharmacognosy and Materia Medica in the Massachusetts College of Pharmacy. Fifth Edition, Revised and Enlarged with 387 Illustrations and Glossary of Botanical Terms. P. Blakiston's Son & Company, Philadelphia. 1927.

This well known work is now in its fifth edition. Although it is written chiefly for the use of students of pharmacy, the physician may often find items of interest in it such as descriptions and cuts of plants important as sources of drugs; common poisonous plants; microscopic tests for important poisons, etc. It contains much more than a physician, at least, would expect to find in a work with the title: "Pharmaceutical Botany."

Health Behavior. By THOMAS D. WOOD and MARION OLIVE LERRIGO. Public School Publishing Co., Bloomington, Ill.

A book purporting to give in outline form the appropriate development of the child from birth to adult life—a sort of Binet scale of health habits, both mental, social and physical.

Scale 1, represents the habits which should be acquired before entering kindergarten; scale 2, from kindergarten to the third grade; scale 3, to the end of the sixth grade; scale 4, to the end of the ninth grade; scale 5, to the end of the 12th grade; scale 6, appropriate for adults.

The idea is excellent and it should prove a useful manual for teachers in primary and secondary schools. There is a great deal of repetition and the book would benefit by its elimination.

Examination of Children. By *Clinical and Laboratory Methods.* By ABRAHAM LEVINSON, B.S., M.D. St. Louis. The C. V. Mosby Company, 1927.

This is a complete work on the physical examination of the child and infant, suitable rather for the student than for the practitioner, although useful hints and data are contained. There is nothing particularly new in the text; it is a carefully constructed reminder of the way of taking a history and making a physical examination, with interpretations and many illustrations. Many clinical procedures are described which would ordinarily be used only by the trained chemist.

Lectures on Internal Medicine. (Delivered in the United States, 1926.) By KNUD FABER, M.D., Professor of Internal Medicine, University of Copenhagen, Denmark. Paul B. Hoeber, Inc. New York. May, 1927. 140 pages.

Contents: 1. The Etiology and Pathogenesis of Achylia Gastrica. 2. The Intestinal Origin of Pernicious Anemia. 3. Benign Glycosuria. 4. Historical Outline of Medical Therapy, A Sketch.

It is a gracious act of hospitality to preserve in permanent form the lectures presented to the American Medical Profession by Professor Knud Faber of Denmark during his visit to the United States in 1926. They deal with problems of interest and importance in clinical medicine.

Professor Faber presents achylia gastrica in the light of a true gastritis, not merely a gastric catarrh, but a disease of the glandular parenchyma of an inflammatory nature, analogous to nephritis and hepatitis. In the lecture on pernicious anemia he stresses the fact that the pathogenesis of this disease has its origin in intestinal intoxication by a protein toxin. The thesis of his lecture on benign glycosuria is that the blood sugar threshold is constant in every individual whether diabetic or non-diabetic. In the final lecture he sketches the history of medical therapy presenting some fine illustrations of methods and men and discussing some of the problems of the recent day methods.

On the whole this little volume presents in an interesting and authoritative manner some important problems in clinical medicine. It is well worth being added to one's library.